

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11545

11555 CERTIFICATE OF DEATH

Reg. Dist. No. 30

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Balto.</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Balto.</u>	
CITY OR TOWN <u>Catonsville</u>		LENGTH OF STAY (in this place)		CITY OR TOWN <u>Catonsville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>404 Waveland Ave.</u>				STREET ADDRESS (If rural give location) <u>404 Waveland Ave.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Amelia</u> (Middle) <u>Alasha</u> (Last)				(Month) <u>Dec.</u> (Day) <u>20</u> (Year) <u>19 55</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>June 16, 1897</u>	9. AGE last birthday <u>58</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>--- Canarata</u>				14. MOTHER'S MAIDEN NAME <u>Not Known</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>---</u>		16. SOCIAL SECURITY NO. <u>-----</u>		17. INFORMANT & ADDRESS <u>Anthony Alasha 404 Waveland Ave.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.1 IMMEDIATE CAUSE (A) <u>CORONARY Thrombosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>12/20/55</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>ARTERIOSCLEROTIC Cardiovascular</u>				<u>2+ yrs</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>AN DISEASE</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 20, 1954</u> , to <u>12/20, 1955</u> , that I last saw the deceased alive on <u>12/19, 1955</u> , and that death occurred at <u>1:20</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Thos E. Roach</u>		ADDRESS (Street, city, town, state) <u>M.D. 3629 Edmonston Av Balto</u>		DATE SIGNED <u>12/22/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12-24-55</u>		NAME OF CEMETERY OR CREMATORY <u>Cathedral Cem.</u>		LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
24. REC'D BY REGISTRAR <u>DEC 22 1955</u>		REGISTRAR'S SIGNATURE <u>V. E. Harvey</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Fairley Funeral Home, Catonsville, Md.</u>		ADDRESS	

BUREAU V. S.

DEC 28 1955

RECEIVED

11556

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Baltimore		MARYLAND		STATE Md.		COUNTY Baltimore City	
CITY (If outside corporate limits, write RURAL and give nearest town) 52 Catonsville Md.		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) Baltimore City			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Paradise & Altamont Aves. Paradise Nursing Home				STREET ADDRESS (If rural give location) 3718 Boardman Avenue			
3. NAME OF DECEASED: (Type or Print) Grace M. Albright				4. DATE (Month) (Day) (Year) OF DEATH: Dec. 17, 1955			
5. SEX: Female		6. COLOR OR RACE: White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed		8. DATE OF BIRTH: July 12, 1935	
9. AGE last birthday: 70 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		11. BIRTHPLACE (State or foreign country): Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: William H. Miller				14. MOTHER'S MAIDEN NAME: Ide Virginia Ashlook			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: George W. Mitchell 5602 Wayne Ave.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Myocardial failure						36 hrs	
ANTECEDENT CAUSE (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) Arteriosclerosis, gen. atherosclerosis						Unknown	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Nov 20, 1955 , to Dec 17, 1955 , that I last saw the deceased alive on Dec 16, 1955 , and that death occurred at 2:00 A.M. from the causes and on the date stated above.							
SIGNATURE Stephen Lee Neaguess				ADDRESS Catonsville Md.		DATE SIGNED 12-19-55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		Dec. 19, 1955		London Park Cemetery		Baltimore, Maryland	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS Ellsworth Armistead 4800 Liberty Heights Ave.			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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11557

11547

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 45

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY BALTIMORE	MARYLAND	STATE Md	COUNTY Balto
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Middle River	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Middle River	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 2100 Eastern Blvd.		STREET ADDRESS (If rural, give location) 2100 Eastern Blvd. zone 20	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) ELMER	(Middle) O.	(Last) ANDERSON	(Month) 12 (Day) 31 (Year) 1955
5. SEX: M	6. COLOR OR RACE: M	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): unknown	8. DATE OF BIRTH: unknown
9. AGE last birthday: 52 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Process		10b. KIND OF BUSINESS OR INDUSTRY: Packing club	
11. BIRTHPLACE (State or foreign country): Md		12. CITIZEN OF WHAT COUNTRY: USA	
13. FATHER'S NAME: unknown		14. MOTHER'S MAIDEN NAME: unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No.		16. SOCIAL SECURITY No.: 25-16-1086	
17. INFORMANT & ADDRESS: 397 Oriole Ave			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
Immediate cause (a) CORONARY ARTERY SCLEROSIS		
DUE TO WITH MYOCARDIAL INFARCTION		
Antecedent cause(s) (b) With MYOCARDIAL INFARCTION		
Diseases or conditions, if any, giving rise to the above cause DUE TO With MYOCARDIAL INFARCTION		
stating underlying cause last (c)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
19a. DATE OF OPERATION: 4/4/56	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		
SIGNATURE R. F. Fisher		CHIEF MEDICAL EXAMINER DATE SIGNED 12-31-55
M. D. DEPUTY MEDICAL EXAMINER		ASSISTANT MEDICAL EXAM.
23. BURIAL, CREMATION, REMOVAL (Specify): Burial	DATE THEREOF 1/4/56	NAME OF CEMETERY OR CREMATORY Mt. Vernon Memorial Park
LOCATION (City, town, or county) (State) Balto Co Md.	24. FUNERAL DIRECTOR J. Bugajski	ADDRESS 1407 Eastern Ave
DATE REC'D BY LOCAL REG. 1/4/56	REGISTRAR'S SIGNATURE Edith Hurley	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 6 1955

RECEIVED
BUREAU

JAN 6

11558 CERTIFICATE OF DEATH

Reg. Dist. No. 30

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Catonsville 28</u>		<u>From 11/13/55</u>		TOWN <u>Baltimore 17</u>		<u>3Y01-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove Hospital</u>				STREET ADDRESS (If rural give location) <u>189 Lannale St</u>			
3. NAME OF DECEASED (Type or Print) <u>Fello, Frederick E</u> (First) <u>ANDERSON</u> (Last)				4. DATE OF DEATH (Month) <u>12</u> (Day) <u>14</u> (Year) <u>1955</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>M</u>	8. DATE OF BIRTH <u>9.18.81</u>	9. AGE last birthday <u>74</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Investment Broker Finance</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Iowa USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>William Anderson</u>				14. MOTHER'S MAIDEN NAME <u>Helen Van Metre</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>1904-1921</u>		17. INFORMANT & ADDRESS <u>Spring Grove Hospital Records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
<u>493X</u> IMMEDIATE CAUSE (A) <u>Pneumonia</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Generalized Arteriosclerosis</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11/13</u> , 19 <u>55</u> , to <u>12/14</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12/14</u> , 19 <u>55</u> , and that death occurred at <u>4:15 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Rena Becker</u> M.D.				DATE SIGNED <u>12/14/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Dec. 16, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		LOCATION (City, town, or county) <u>Catonsville, Balto. Co., Md.</u>	
24. REC'D BY REGISTRAR <u>Dec. 15, 1955</u>		REGISTRAR'S SIGNATURE <u>V. E. Harris</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John O. Mitchell & Sons Inc., 1900 Eutaw Pl.</u>			

1958 CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

187 January 2
H. Green 17

1913/12
Mary Green

22	11	51	12	18	21	12	18	21	12	18	21
12	18	21	12	18	21	12	18	21	12	18	21

William Anderson

Presbyterian

Interment

BUREAU V. S.

DEC 16 1955

RECEIVED

12/12
12/14
12/14

Gene Becker

RECEIVED

ADDITIONAL INFORMATION ON DEATH OF

11559

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>md.</u>		COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>WHITE MARSH</u>		<u>3 YRS</u>		TOWN <u>WHITE MARSH</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>H.A. TAYLOR PRIVATE HOME</u>				STREET ADDRESS (If rural give location) <u>WHITE MARSH, MD.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Louis S.</u> (Middle) <u>Armiger</u> (Last)				(Month) <u>Dec.</u> (Day) <u>2</u> (Year) <u>1955</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>SEPT. 21, 1869</u>	9. AGE last birthday <u>86</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
					Months <u>2</u>	Days <u>11</u>	Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TRUCKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B.T.O.-RR</u>		11. BIRTHPLACE (State or foreign country) <u>A.A. COUNTY, MD.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>FRANK A. ARMIGER</u>				14. MOTHER'S MAIDEN NAME <u>SARAH HARRISON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No.</u> (If Yes, give year or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS <u>JOHN H. ARMIGER</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.1 IMMEDIATE CAUSE (A) <u>CORONARY occlusion</u>				INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic Cardio-Vascular Disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
		M.					
22. I hereby certify that I attended the deceased from <u>MARCH 1955</u> to <u>DEC. 2, 1955</u> , that I last saw the deceased alive on <u>Dec. 1</u> , 1955, and that death occurred at <u>7 P.</u> M., from the causes and on the date stated above.							
SIGNATURE <u>William A. Tyson</u>		M.D. <u>Kingsoille Md</u>		ADDRESS (Street, city, town, state)		DATE SIGNED <u>12-3-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>Dec. 5, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Quaker Burial Ground</u>		LOCATION (City, town, or county) (State) <u>Gaithersville, Md.</u>	
24. REC'D BY REGISTRAR <u>DEC 8</u>		REGISTRAR'S SIGNATURE <u>Dr. Walter Hammett</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Fred H. Cole</u>		ADDRESS <u>1913 W. Balto. St</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

CERTIFICATE OF DEATH

MASS. REG. NO.

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

Handwritten text in the main body of the certificate, including fields for name, age, sex, and cause of death. The text is mostly illegible due to fading and bleed-through.

BUREAU V. S.

DEC 9 1935

RECEIVED

11560

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

COUNTY

Baltimore

MARYLAND

CITY (If outside corporate limits, write RURAL
OR and give nearest town)TOWN *Catonsville*LENGTH OF STAY
(In this place)

5 yrs.

HOSPITAL OR
INSTITUTION OR
STREET ADDRESS9. *Caton Ridge Nursing Home*

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE *Maryland* COUNTYCITY (If outside corporate limits, write RURAL and give nearest town)
ORTOWN *Baltimore*STREET
ADDRESS

(If rural give location)

3. NAME OF
DECEASED:
(Type or Print)

(First)

Ruth

(Middle)

Sullivan

(Last)

Arthur

4. DATE (Month)

OF

DEATH: *Dec.*

(Day)

26

(Year)

1955

5. SEX:

*Female*6. COLOR OR
RACE:*White*7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify)*Widowed*

8. DATE OF BIRTH:

Sept. 20, 1866

9. AGE last birthday

89

IF UNDER 1 YEAR

Months

Days

IF UNDER 24 HRS.

Hours

Min.

10A. USUAL OCCUPATION (Give kind of
work done during most of working life,
even if retired):*at home*10B. KIND OF BUSINESS
OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

*Mt. Pleasant, Iowa*12. CITIZEN OF WHAT
COUNTRY?

13. FATHER'S NAME:

Michael Frederick Sullivan

14. MOTHER'S MAIDEN NAME:

*Catherine Fagan*15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unk.) (If Yes, give war or dates
of service)*No*

16. SOCIAL SECURITY NO.

None

17. INFORMANT & ADDRESS:

Margaret Arthur O'Connor - 3417 Turner

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1

IMMEDIATE CAUSE

(A)

DUE TO

Cerebral thrombosis

ANTECEDENT CAUSE (S):

(B)

DUE TO

*Arterio sclerosis*DISEASES OR CONDITIONS, IF ANY,
GIVING RISE TO THE ABOVE CAUSE
STATING UNDERLYING CAUSE LAST.

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)21B. PLACE (Home, farm, factory,
OF INJURY street, office bldg., etc.)21C. WHERE DID (City or town)
INJURY OCCUR?

(County)

(State)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

M.

21E. INJURY OCCURRED
While ☐ Not while ☐
at work at work

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *October, 1951* to *Dec 26, 1955* that I last saw the deceasedalive on *Dec 26, 1955*, and that death occurred at *3:05 P.M.* from the causes and on the date stated above.

SIGNATURE

Carl Robert Jr.

ADDRESS

M.D. 4605 Edmonson Ave

DATE SIGNED

*12/27/55*23. BURIAL, CREMATION,
REMOVAL (SPECIFY)*Burial*

DATE THEREOF

12/28/1955

NAME OF CEMETERY OR CREMATORY

Mt. Olivet Cemetery

LOCATION (City, town, or county)

*Washington, D. C.*DATE REC'D BY LOCAL
REGISTRAR*12/24/55*

REGISTRAR'S SIGNATURE

C. H. Helrich

24. FUNERAL DIRECTOR

Ellsworth Armacost

ADDRESS

4600 Liberty Hgts. Ave.

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct name is especially important. Physicians: please write the causes of death clearly and legibly.



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11551

CERTIFICATE OF DEATH

11551

Reg. Dist. No. 44

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Talbot</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Fort Howard</u>		<u>112 Days</u>		OR TOWN <u>McDaniel</u>		<u>7'</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>JOHN D. BAILEY</u>				<u>December 9, 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>Colored</u>	<u>Married</u>	<u>12-18-87</u>	<u>67</u>	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Waterman</u>		<u>Tonging Oysters</u>		<u>Bozman, Maryland</u>		<u>U. S. A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>John Bailey, Sr.</u>				<u>Margaret Chester</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>Yes</u>		<u>WW I</u>		<u>218-12-1731</u>		<u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
441 IMMEDIATE CAUSE (A) <u>BILATERAL LOBULAR PNEUMONIA</u>						<u>UNKNOWN</u>	
ANTECEDENT CAUSE(S) <u>EMACIATION SECONDARY TO COMPLETE GASTRECTOMY</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>(FOR CARCINOMA OF STOMACH)</u>						<u>1 YEAR</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<u>1-10-55</u>		<u>Esophagogastrectomy and Splenectomy</u>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Aug. 19, 1955</u> to <u>Dec. 9, 1955</u> and that death occurred at <u>4:10 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Donald D. Mark, M.D.</u>				ADDRESS (Street, city, town, state) <u>M.D. VAH, FORT HOWARD, MARYLAND</u>		DATE SIGNED <u>12-10-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>12-14/55</u>		<u>Asbury Methodist Cemetery</u>		<u>Bozman, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>DEC 14 1955</u>		<u>Dawson L. Farley</u>		<u>I. B. Dashiell</u>		<u>Dover Street, Easton, Md.</u>	

RECEIVED

DEC 14 1955

BUREAU V. S.

11552

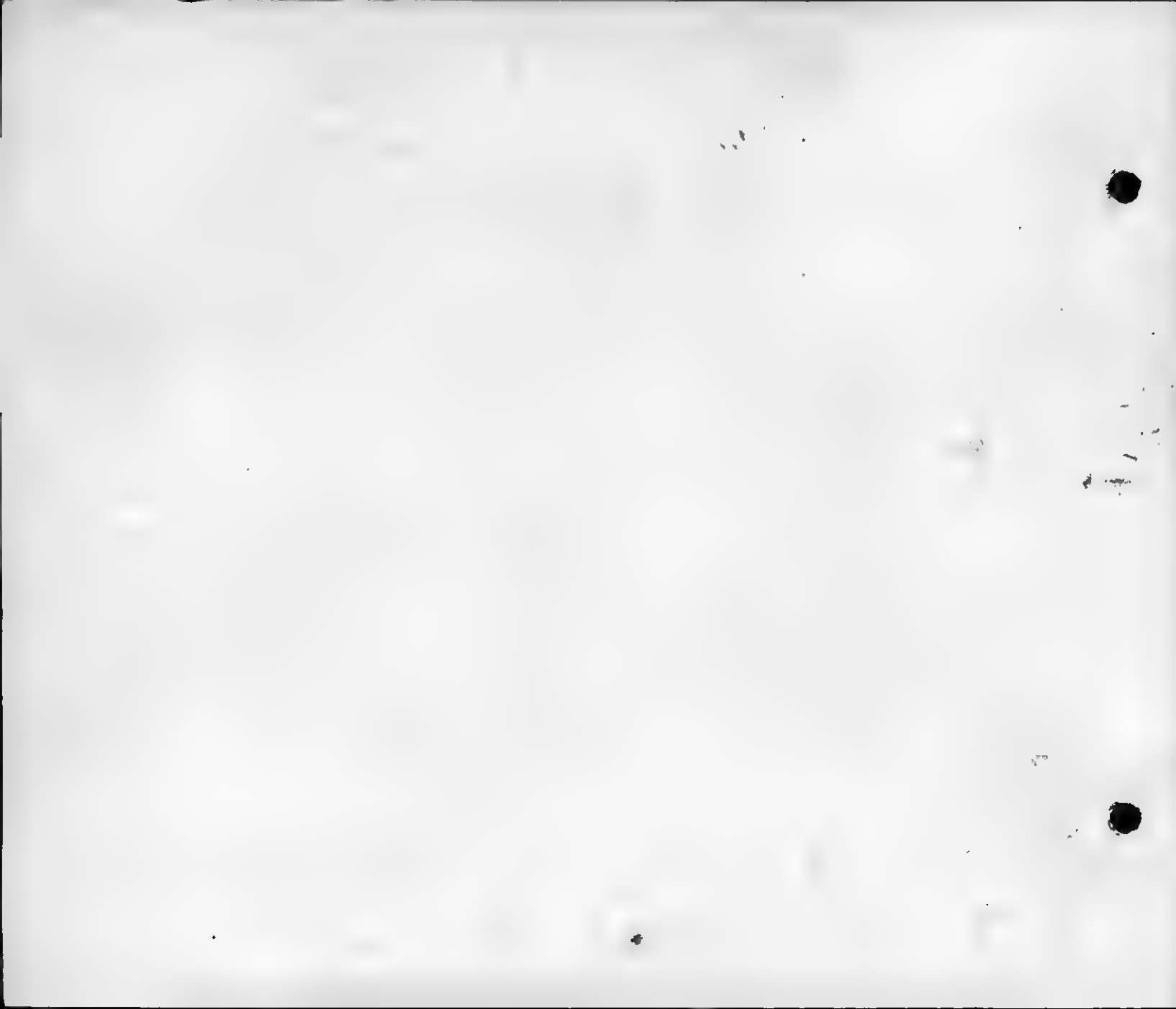
CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Balto.</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>52 Catonsville</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Catonsville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>112 Oakdale Ave.</u>				STREET ADDRESS (If rural give location) <u>112 Oakdale Ave.</u>			
3. NAME OF DECEASED: (First) <u>L.</u> (Middle) <u>GRACE</u> (Last) <u>BAKER</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>Dec. 9, 19 55</u>			
5. SEX: <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>single</u>	8. DATE OF BIRTH: <u>Apr. 6, 1866</u>	9. AGE last birthday <u>89</u> yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>never worked</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>---</u>		11. BIRTHPLACE (State or foreign country): <u>Md.</u>	
13. FATHER'S NAME: <u>William Baker</u>				14. MOTHER'S MAIDEN NAME: <u>Willimina Durham</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Miss Emma Baker-112 Oakdale Ave.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Antibiotic cardiovascular disease</u>						<u>Days +</u>	
ANTECEDENT CAUSE (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>---</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb.</u> , 19 <u>53</u> , to <u>Dec. 9.</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>November 23, 19 55</u> , and that death occurred at <u>5:30 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>John A. Hubert</u>				DATE SIGNED <u>M. D. 11/8 St. Paul St. Baltimore 12-10-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12/10/55</u>		NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cem.</u>		LOCATION (City, town, or county) (State) <u>Balto., Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>December 10 1955</u>		REGISTRAR'S SIGNATURE <u>R.W.</u>		24. FUNERAL DIRECTOR <u>Thos. J. Pickens & Sons - Balto.</u>		ADDRESS <u>Md. 17</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



11563

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Baltimore		MARYLAND		STATE Maryland		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Ruxton				TOWN Baltimore		3Y01-4	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Sorrenson Nursing Home 7912 Ruxway Road				STREET ADDRESS (If rural give location) 246 N. Pearl Street			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) MARY		(Middle) IDA		(Last) BAKER		(Month) Dec. 7, 1955	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
female	white	married	July 2, 1875	80 yrs.	Months Days	Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
housewife		at home		Carroll County, Maryland		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Francis Haines				Barbara Albaugh			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
		none		Mary Leisure, 1340 Sargeant St.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Myocardial failure acute						1 hour	
ANTECEDENT CAUSE(S) DUE TO Myocarditis chronic						5 years	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO Hypertrophy myocardium						5 years	
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Ascites general.						2 months	
19a. -DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
none		none					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
		none		none			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21f. HOW DID INJURY OCCUR?			
no injury				none			
22. I hereby certify that I attended the deceased from 12-5th-1955, to 12-7th-1955, that I last saw the deceased alive on Dec 6th, 1955, and that death occurred at 2:00 P.M. from the causes and on the date stated above.							
SIGNATURE James Graham Martin				ADDRESS (Street, city, town, state) 516 Cathedral Street Baltimore Md 12/6/55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
burial		12/10/55		St. Paul's Evangelical Lutheran Church Cemetery		Arcadia, Maryland	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE 12-10-55		Mabel Gray		Wm. L. L. Inc.		1217 St. Paul Street	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M



11564

CERTIFICATE OF DEATH

Reg. Dist. No. 43

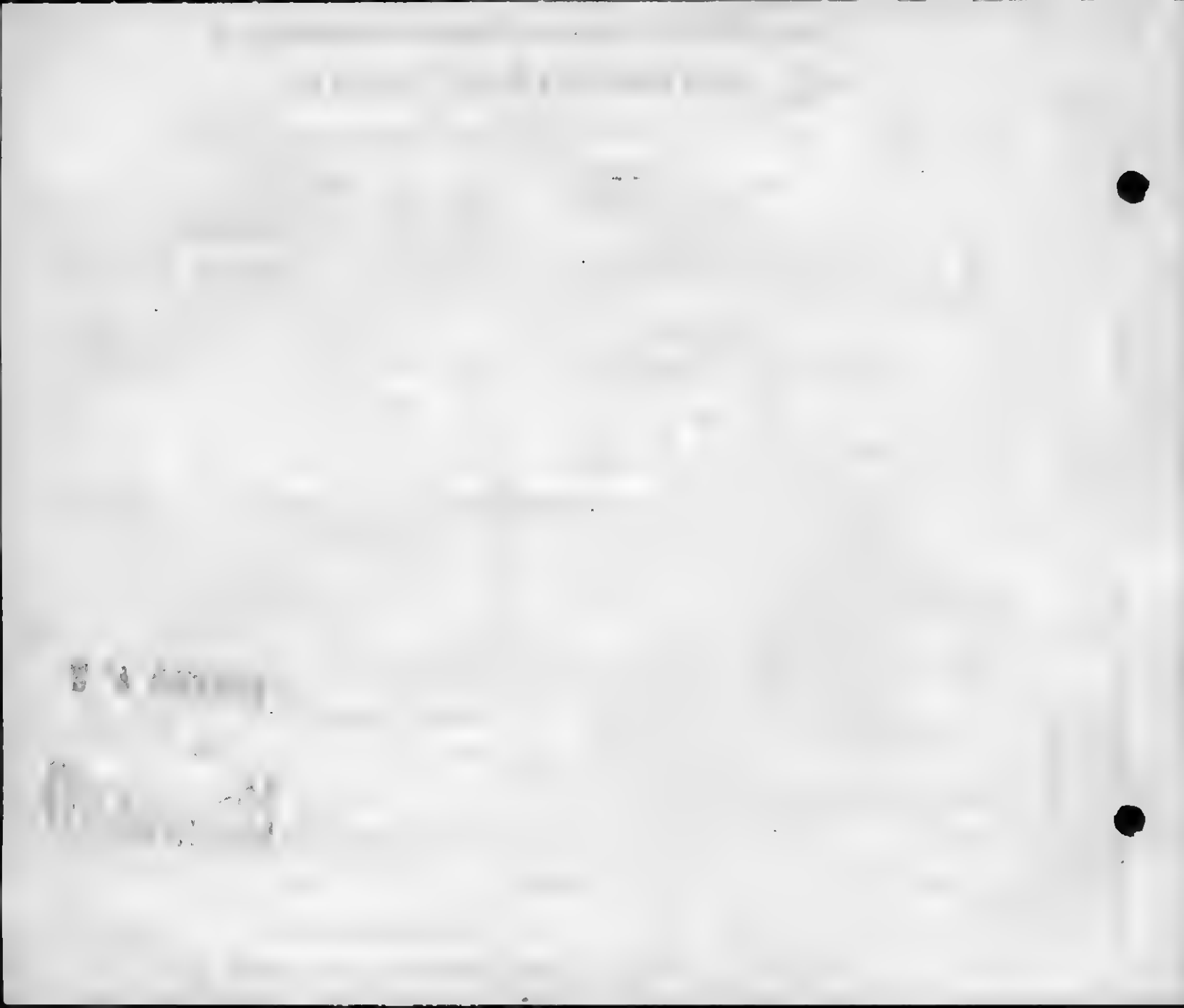
1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Balto</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Balto</u>	
CITY (if outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (if outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Raspensburg</u>		<u>Life</u>		TOWN <u>Raspensburg</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>711 Elmwood Rd</u>				STREET ADDRESS (if rural give location) <u>711 Elmwood Rd</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Charles</u> (Middle) <u>F</u> (Last) <u>Balster</u>				(Month) <u>Dec</u> (Day) <u>27</u> (Year) <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>Dec 18-1878</u>	<u>77</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
<u>Laborer Retired</u>				<u>Light House</u>		<u>Balto md</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>George Balster</u>				<u>Eva Ritterpusch</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
<u>NO</u>				<u>None</u>		<u>Mrs Harold Allison, 711 Elmwood Rd</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>CORONARY ARTERY THROMBOSIS</u>						<u>6 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>CORONARY ARTERIO SCLEROSIS</u>						<u>5 yrs +</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>CHRONIC NEPHRITIS</u>						<u>5 yrs +</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>9/19</u> , 19 <u>58</u> , to <u>12/27</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12/26</u> , 19 <u>55</u> , and that death occurred at <u>5:10</u> AM, from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city, town, state) <u>6331 Belair Rd, Balto md</u>		DATE SIGNED <u>12/27/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>12/30/55</u>		<u>Parkwood Cem</u>		<u>Balto md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>DEC 1955</u>		<u>Mrs. A. L. Reford</u>		<u>Lassalme Funeral Home</u>		<u>7461 Belair Rd</u>	

INSTRUCTIONS

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TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M



11555

CERTIFICATE OF DEATH

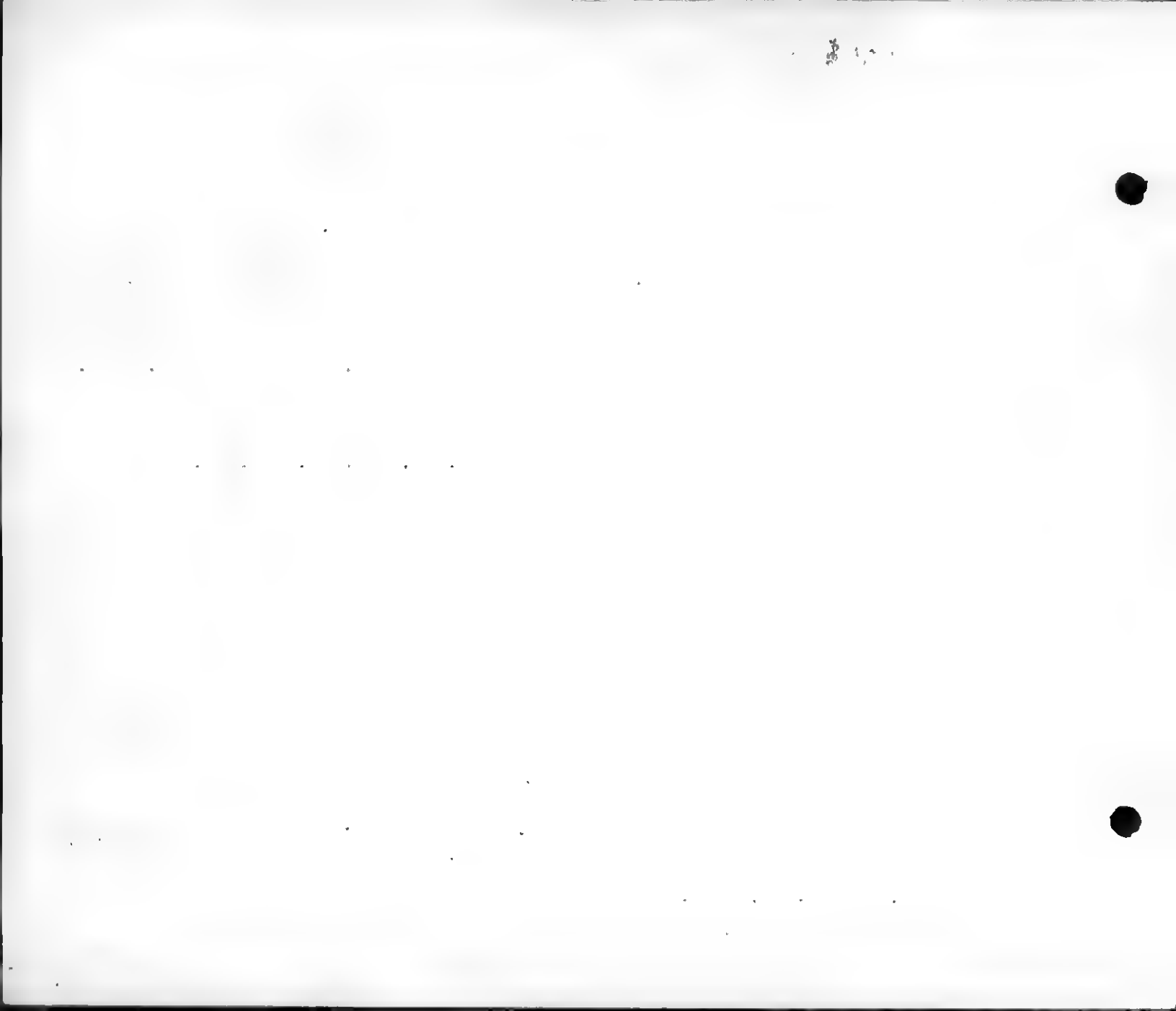
Reg. Dist. No. 44

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <u>BALTIMORE</u>		MARYLAND	STATE <u>MARYLAND</u> COUNTY		
CITY (If outside corporate limits, write RURAL and give nearest town) <u>FORT HOWARD,</u>		LENGTH OF STAY (in this place) <u>11</u> DAYS	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>BALTIMORE</u>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>VETERANS ADMINISTRATION HOSPITAL</u>			STREET ADDRESS (If rural give location) <u>1611 N. PAYSON STREET</u>		
3. NAME OF DECEASED: (First) (Middle) (Last) <u>OWEN D. BARFIELD</u>			4. DATE (Month) (Day) (Year) OF DEATH: <u>December 11, 1955</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>COLORED</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>MARRIED</u>	8. DATE OF BIRTH: <u>3-25-96</u>		9. AGE last birthday <u>59</u> yrs.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>CONSTRUCTION COMPANY</u>		11. BIRTHPLACE (State or foreign country): <u>SNOW HILL, N. CAROLINA</u>	
13. FATHER'S NAME: <u>JOSUE BARFIELD</u>			14. MOTHER'S MAIDEN NAME: <u>LEVINA EDWARDS</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>YES</u>		16. SOCIAL SECURITY NO. <u>578-10-0448</u>		17. INFORMANT & ADDRESS: <u>CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MARYLAND</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH		
4 IMMEDIATE CAUSE (A) <u>ACUTE CORONARY THROMBOSIS</u>			RECENT		
ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u>			UNKNOWN		
DUE TO (C) <u>ARTERIOSCLEROSIS, GENERALIZED</u>			UNKNOWN		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>NOV. 27, 1955</u> , to <u>DEC. 11, 1955</u> , and that death occurred at <u>3:30 PM</u> , from the causes and on the date stated above.					
SIGNATURE <u>Francis G. Dickey, M.D.</u>		ADDRESS <u>Chief, Medical Service, VAH, FORT HOWARD, MARYLAND</u>		DATE SIGNED <u>12-12-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>12-15-55</u>		NAME OF CEMETERY OR CREMATORY <u>BALTIMORE NATIONAL</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Dec 13, 1955</u>		REGISTRAR'S SIGNATURE <u>G. L. V. [Signature]</u>		24. FUNERAL DIRECTOR <u>Charles Law Mortuary, 802-04 Madison Ave.</u>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 11556

11556

CERTIFICATE OF DEATH

Reg. Dist. No. 44

Item 16, Film E191 1-25-56 et

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>BALTIMORE</u>		MARYLAND		STATE <u>NORTH CAROLINA</u>		COUNTY <u>AYDEN</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>TOWN FORT HOWARD</u>		LENGTH OF STAY (in this place) <u>7 Hrs.</u>		CITY: If outside corporate limits, write RURAL and give nearest town) <u>OR TOWN AYDEN</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>VETERANS ADMINISTRATION HOSPITAL</u>				STREET ADDRESS (If rural give location) <u>ROUTE #1</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>HUGH (NMI) BARRETT</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>December 23, 1955</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>Colored</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH: <u>May 3, 1919</u>	
9. AGE last birthday <u>36</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Farmer</u>		11. BIRTHPLACE (State or foreign country): <u>Pitt Co., North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>ALBERT BARRETT</u>				14. MOTHER'S MAIDEN NAME: <u>EMMA PAYTON</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes</u> <u>WW-11</u>				16. SOCIAL SECURITY NO. <u>243-20-2273</u>		17. INFORMANT & ADDRESS: <u>Clin. Rec. Vet. Adm. Hosp., Ft. Howard, Md.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						UNKNOWN	
IMMEDIATE CAUSE (A) <u>NEPHROSCLEROSIS, ALIGNANT PHASE</u>							
ANTECEDENT CAUSE (B) <u>DUE TO</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>DUE TO</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>HYPERTENSIVE CARDIOVASCULAR DISEASE UREMIA</u>						UNKNOWN UNKNOWN	
19A. DATE OF OPERATION: <u>12-26-55</u>						19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Dec. 22, 1955, to Dec. 23, 1955, and that death occurred at 6:25 AM, from the causes and on the date stated above.							
SIGNATURE <u>FRA. CIS G. DICKEY, M.D.</u>				ADDRESS <u>VAH, Fort Howard, Md.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>REMOVAL</u>		DATE THEREOF <u>12-26-55</u>		NAME OF CEMETERY OR CREMATORY <u>BARRETT C EMETERY</u>		LOCATION (City, town, or county) (State) <u>Rt. #1, AYDEN, North Carolina</u>	
DATE REC'D BY LOCAL REGISTRAR <u>DEC 24 1955</u>		REGISTRAR'S SIGNATURE <u>H. H. H. H. H.</u>		24. FUNERAL DIRECTOR <u>W. G. Nelson</u>		ADDRESS <u>1348 N. Calhoun</u>	

RECEIVED U. S.

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RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11557

11567

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTO.</u>		STATE <u>Md.</u> COUNTY <u>BALTO.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>SPARROWS PT. 19</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>SPARROWS PT. 19</u>	
OR TOWN <u>SPARROWS PT. 19</u>		LENGTH OF STAY (in this place) <u>36 YRS</u>		OR TOWN <u>SPARROWS PT. 19</u>		OR TOWN <u>SPARROWS PT. 19</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>912 D ST.</u>		STREET ADDRESS (If rural give location) <u>912 D ST.</u>					
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>GEORGE</u> (Middle) <u>HARLEM</u> (Last) <u>BARTHOLOMEW</u>				(Month) <u>12</u> (Day) <u>6</u> (Year) <u>1955</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>JAN. 11, 1885</u>	9. AGE last birthday <u>70</u> yrs.	IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u>	IF UNDER 24 HRS. Hours <u>1</u> Min <u>33</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FOREMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>STEEL WFR.</u>		11. BIRTHPLACE (State or foreign country) <u>YENNA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GEO. BARTHOLOMEW</u>				14. MOTHER'S MAIDEN NAME <u>NONN TURKES</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>213-07-6363</u>		17. INFORMANT & ADDRESS <u>MARTHA B. BARTHOLOMEW - SAME</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
420.0 IMMEDIATE CAUSE (A) <u>Acute Congestive Heart Failure</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic Heart Disease</u>						<u>10 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u></u>							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work Not while at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan 1, 1955, to Dec 6, 1955, that I last saw the deceased alive on Dec 5, 1955, and that death occurred at 7:35 A.M. from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>		M.D. <u>520 D St. SpR 19</u>		DATE SIGNED <u>12-6-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>12/9/55</u>		NAME OF CEMETERY OR CREMATORY <u>MEADOWBROOK</u>		LOCATION (City, town, or county) <u>HOWARD CO. Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>L. Harker</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>[Address]</u>	
DATE <u>12-8-55</u>							

U.S. ARMY

DEC 12 1944

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

11558

2411 N. Charles Street, Baltimore

11558

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD.</u> COUNTY <u>Baltimore</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Notch Cliff near Towson</u>				CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Notch Cliff near Towson</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Villa Maria Glenarm Rd</u>				STREET ADDRESS (If rural, give location) <u>Glenarm Rd</u>			
3. NAME OF DECEASED (Type or Print) <u>Sister Mary Gerardus Becker</u>		(First) (Middle) (Last)		4. DATE OF DEATH <u>Dec. 15 1955</u>		(Month) (Day) (Year)	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Aug 7, 1872</u>	9. AGE last birthday <u>83</u> yrs.	If under 1 year Months Days Hours Min.		If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RELIGIOUS.</u>		11. BIRTHPLACE (State or foreign country) <u>Philadelphia, PA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Stephen Becker</u>				14. MOTHER'S MAIDEN NAME <u>Esther Heurich</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>- -</u>				16. SOCIAL SECURITY No. <u>- -</u>		17. INFORMANT AND ADDRESS <u>Sr. Mary Clara Notch Cliff</u>	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Coronary Thrombosis</u>						<u>5 days</u>	
Antecedent cause(s) (b) <u>O. Vesity</u>						<u>10 yrs</u>	
(c)							
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>							
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct 14</u> , 1952, to <u>Dec 15</u> , 1955, that I last saw the deceased alive on <u>Dec 13</u> , 1955, and that death occurred at <u>2:30 A.</u> m., from the causes and on the date stated above.							
SIGNATURE <u>Charles F. O'Donnell</u>				ADDRESS <u>7501 York Rd</u>		DATE SIGNED <u>12/15/55</u>	
23. BURIAL CREMATION REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>12-17-55</u>		<u>VILLA MARIA CEM.</u>		<u>NOTCH CLIFF NRTOWSON, MD</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>12/16/55</u>		<u>Chas. H. H. H. H.</u>		<u>Charles J. Geiler</u>		<u>901 S. CONKLING ST. BALTO, 24, MD.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age especially important. Physicians: please write the causes of death clearly and legibly.



11569

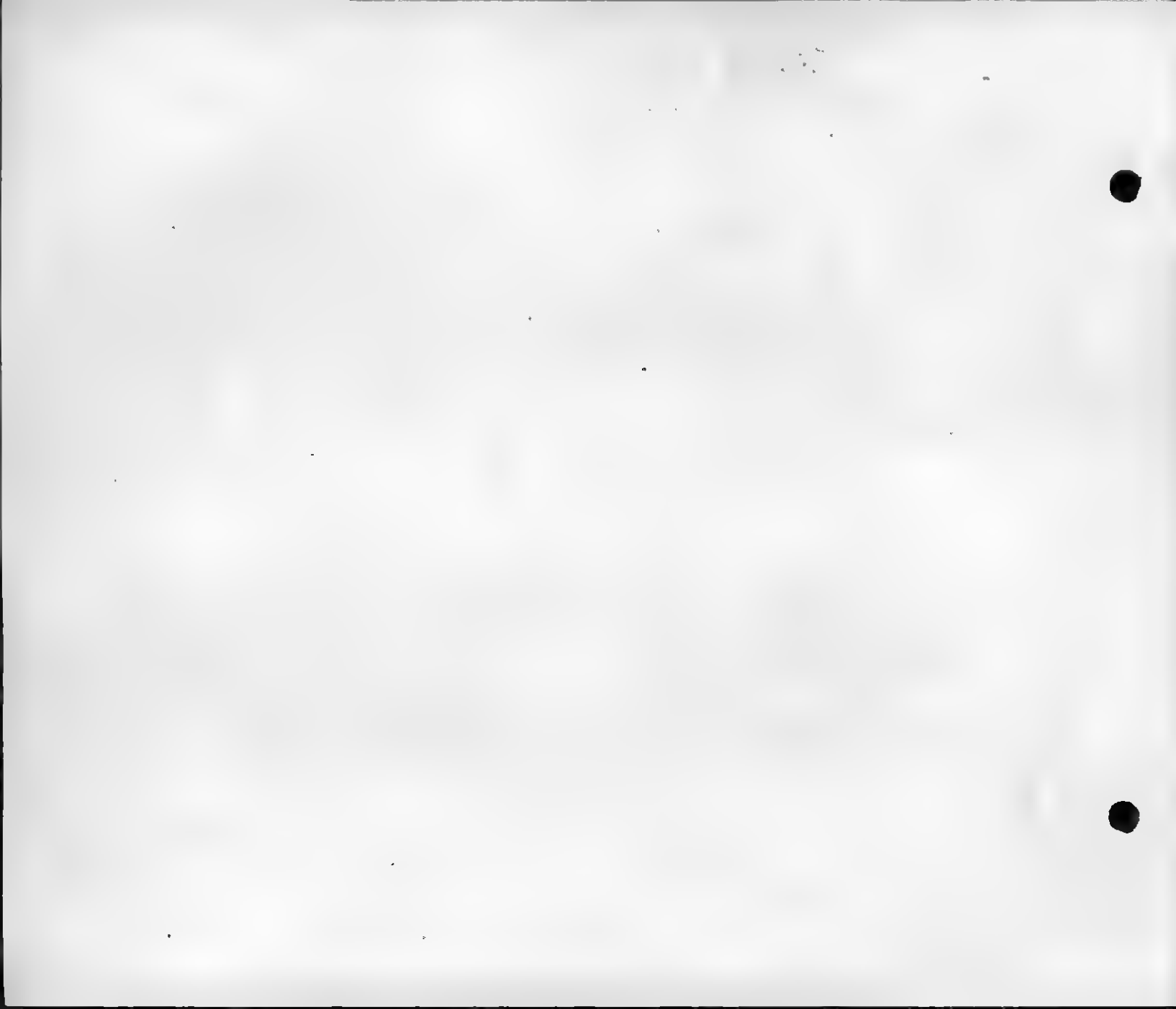
CERTIFICATE OF DEATH

Reg. Dist. No. —

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:							
COUNTY <u>Balto.</u>	MARYLAND	STATE <u>Md.</u>	COUNTY						
CITY (If outside corporate limits, write RURAL or and give nearest town) <u>52 Catonsville</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Catonsville</u>							
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>114 Oakdale Ave.</u>		STREET ADDRESS (If rural give location) <u>114 Oakdale Ave.</u>							
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year) OF DEATH:							
<u>ANNA F. BEERS</u>		<u>Dec. 17, 1955</u>							
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:						
<u>female</u>	<u>white</u>	<u>widowed</u>	<u>Sept. 10, 1875</u>						
9. AGE last birthday		10. AGE last birthday							
<u>80</u> yrs.		<u>80</u> yrs.							
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:							
<u>Saleslady</u>		<u>Dept. Store</u>							
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?							
<u>Md.</u>									
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:							
<u>Bernard Fallon</u>		<u>Ella Clarke</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.							
<u>no</u>		<u>220-03-9560</u>							
17. INFORMANT & ADDRESS:		18. MEDICAL CERTIFICATION							
<u>Mrs. John Kaiser-114 Oakdale Ave., Ctnsvle</u>		<table border="1"> <tr> <td>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</td> <td>INTERVAL BETWEEN ONSET AND DEATH</td> </tr> <tr> <td> <u>420.1</u> IMMEDIATE CAUSE ANTECEDENT CAUSE (S): DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. </td> <td> (A) <u>Coronary Occlusion</u> DUE TO (B) <u>Cardio-vascular disease & Hypertension</u> DUE TO (C) </td> </tr> <tr> <td colspan="2">II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</td> </tr> </table>		I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH	<u>420.1</u> IMMEDIATE CAUSE ANTECEDENT CAUSE (S): DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	(A) <u>Coronary Occlusion</u> DUE TO (B) <u>Cardio-vascular disease & Hypertension</u> DUE TO (C)	II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH								
<u>420.1</u> IMMEDIATE CAUSE ANTECEDENT CAUSE (S): DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	(A) <u>Coronary Occlusion</u> DUE TO (B) <u>Cardio-vascular disease & Hypertension</u> DUE TO (C)								
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.									
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION							
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)							
		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?							
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>							
		21F. HOW DID INJURY OCCUR?							
22. I hereby certify that I attended the deceased from <u>Jan 1953</u> , to <u>12/17, 1955</u> , that I last saw the deceased alive on <u>12/16, 1955</u> , and that death occurred at <u>8:00 A.M.</u> from the causes and on the date stated above.									
SIGNATURE <u>Eliot W. Johnson</u>		ADDRESS <u>M. D. 3432 Frederick Ave.</u> DATE SIGNED <u>11/19/55</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF							
<u>Burial</u>		<u>12/20/55</u>							
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)							
<u>Loudon Park Cem.</u>		<u>Balto., Md.</u>							
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE							
<u>Dec 19, 1955</u>		<u>A. U. Hedrick</u>							
24. FUNERAL DIRECTOR		ADDRESS							
<u>Thos. J. Pickney & Sons</u>		<u>Balto., Md.</u>							

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11560

11570

CERTIFICATE OF DEATH

Reg. Dist. No. 3

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Balto.</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Brooklandville</u>				OR TOWN <u>Brooklandville</u> X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (First)		(Middle)		(Last)		4. DATE (Month) (Day) (Year)	
(Type or Print) <u>OWEN</u>		<u>G.</u>		<u>BENNETT</u>		OF DEATH: <u>Dec. 7,</u> <u>1955</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS	
<u>male</u>	<u>white</u>	<u>married</u>	<u>Jan. 11, 1905</u>	<u>50</u> yrs	Months	Days	Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Chemist</u>		<u>Chemical Mfrs</u>		<u>Miss.</u>			
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Raymond Bennett</u>				<u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.		17. INFORMANT & ADDRESS:			
<u>no</u>				<u>Mrs. Gerald R. Bennett-2030 E. Belvedere</u>			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
332X IMMEDIATE CAUSE						<u>10 min.</u>	
ANTECEDENT CAUSE (S):						<u>30 min.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.						<u>Weeks at</u>	
(A) <u>Acute pulmonary edema</u>						<u>least</u>	
DUE TO							
(B) <u>Possible cerebral embolus</u>							
DUE TO							
(C) <u>Art's thrombi, just above aortic ring, one detached</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 18, 1952</u> to <u>Dec 7, 1955</u> , that I last saw the deceased alive on <u>Dec. 7, 1955</u> , and that death occurred at <u>8:15 P. M.</u> from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
<u>Henry Z. Klinefelter R.</u>		<u>1101 N. Calvert St.</u>		<u>12/9/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>12/10/55</u>		<u>Druid Ridge Cem.</u>		<u>Pikesville, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>December 10, 1955</u>		<u>R. W. V.</u>		<u>Thm. J. Pickens & Sons-Balto.</u>		<u>Md.</u>	



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INSTRUCTIONS

I

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11561

11571 CERTIFICATE OF DEATH

Reg. Dist. No. 46

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL or end give nearest town) <u>Perry Hall</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Perry Hall</u>			
TOWN				TOWN			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>4222 Darnell Road</u>				STREET ADDRESS (If rural give location) <u>4222 Darnell Road</u>			
3. NAME OF DECEASED (Type or Print) <u>Mrs. Amelia Beunler</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>December 21st 1955</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>		8. DATE OF BIRTH <u>Oct. 31, 1873</u>	
9. AGE last birthday <u>82</u> yrs.		10. IF UNDER 1 YEAR (Months) (Days)		11. IF UNDER 24 HRS. (Hours) (Min.)			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Hildebrand</u>				14. MOTHER'S MAIDEN NAME <u>Marie Kohler</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Perry Hall, Md. Mrs. Paul Renshaw, 4222 Darnell Road</u>			
(If Yes, give war or dates of service)							
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Hypertensive Arteriosclerotic Heart Disease</u>						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb. 10, 1953</u> , to <u>Dec. 21, 1955</u> , that I last saw the deceased alive on <u>Dec. 21, 1955</u> , and that death occurred at <u>3:15 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Adam J. Swis</u>		M.D. <u>6232 Belair Road, Balt., Md.</u>		DATE SIGNED <u>Dec. 22, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Dec. 24, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
24. REC'D BY REGISTRAR <u>Dr. Walter Hammett</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck, 5305 Harford Road #14</u>		ADDRESS	
DATE <u>Dec. 22, 1955</u>							

BUREAU V

DEC 23

RECEIVED

11572

CERTIFICATE OF DEATH

Reg. Dist. No. 30

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Balto.</u>		MARYLAND		STATE <u>B.</u>		COUNTY <u>B. 100.</u>	
CITY OR TOWN <u>Catonsville</u>		LENGTH OF STAY (in this place)		CITY OR TOWN <u>Catonsville</u>		(If outside corporate limits, write RURAL and give nearest town)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>33 Wilton Ave.</u>				STREET ADDRESS <u>303 Hilton Ave.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Henry</u> (Middle) <u>Joseph</u> (Last) <u>Desold</u>				(Month) <u>Dec.</u> (Day) <u>15</u> (Year) <u>1955</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>Oct. 23, 1939</u>	9. AGE last birthday <u>66</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Police Officer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Balto. Transit</u>	11. BIRTHPLACE (State or foreign country) <u>B.</u>	12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <u>John Desold</u>				14. MOTHER'S MAIDEN NAME <u>Leresa Feder</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>-----</u>		17. INFORMANT & ADDRESS <u>Mrs. Helen Desold 33 Wilton Ave.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>CORONARY THROMBOSIS</u>				INTERVAL BETWEEN ONSET AND DEATH <u>instant</u>			
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (B) <u>ARTEROSCLEROTIC C.V.D.</u>							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. (C)							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec. 1, 1955</u> , to <u>Dec. 15, 1955</u> , that I last saw the deceased alive on <u>12/14, 1955</u> , and that death occurred at <u>10 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>J. E. Lipp</u>				ADDRESS (Street, city, town, state) <u>3325 Frederick Ave</u>		DATE SIGNED <u>Jan 2, 1956</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12-19-55</u>		NAME OF CEMETERY OR CREMATORY <u>Balto. National Cem.</u>		LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>T. E. Lipp</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Farley Funeral Home, Catonsville, Md.</u>			
DATE <u>Dec. 20, 1955</u>							



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

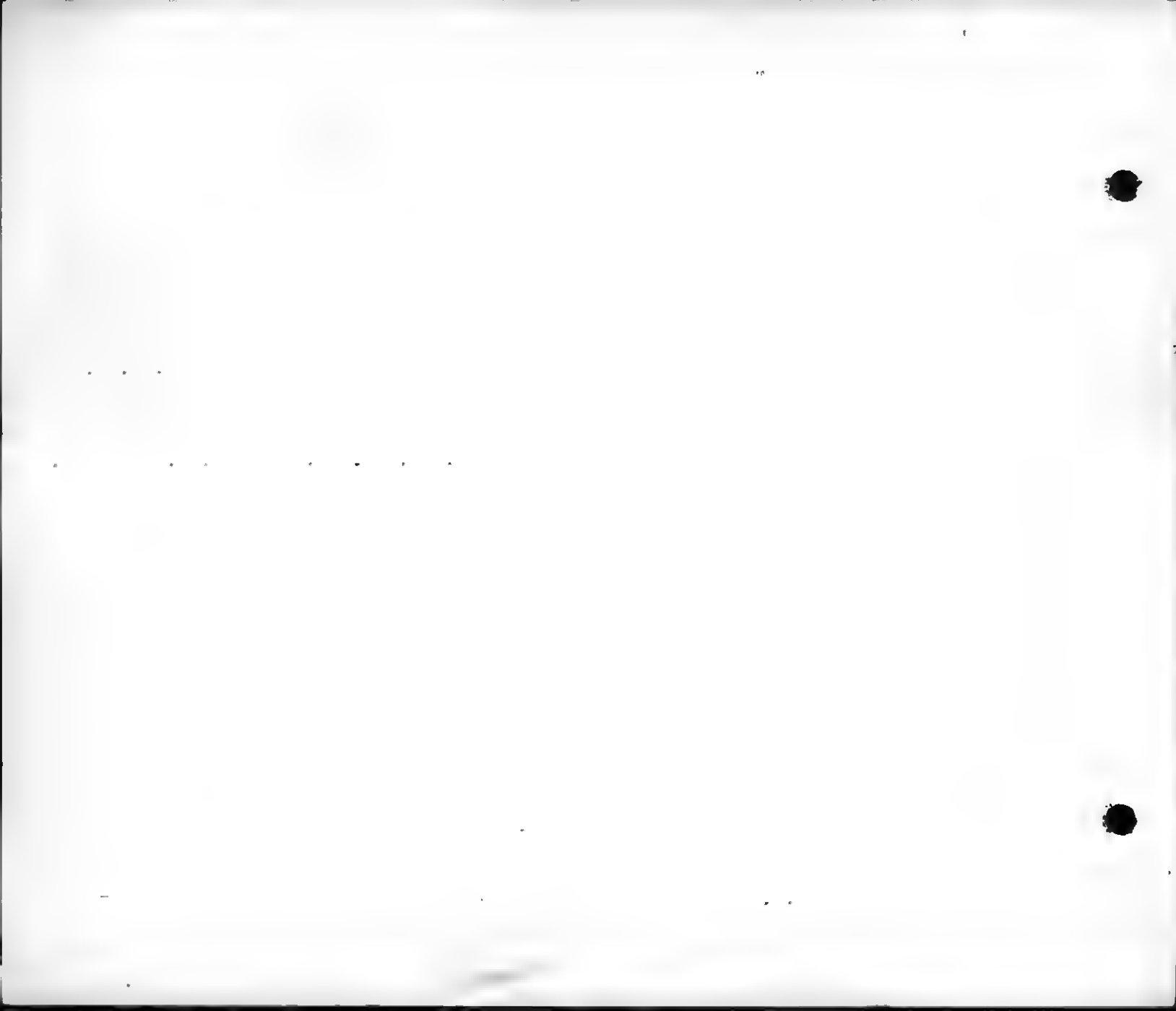
CERTIFICATE OF DEATH

Reg. Dist. No.

11563

11573

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>1</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR			
<u>X</u> TOWN <u>Fort Howard</u>		<u>7 Days</u>		TOWN <u>Baltimore</u> <u>X</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location) <u>831 Frederick Road</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH: <u>December 19 1955</u>			
(Type or Print) <u>ELMER B. BIGGS</u>							
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>11/23/93</u>	9. AGE last birthday <u>62</u> yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fireman</u>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME: <u>William Biggs</u>				14. MOTHER'S MAIDEN NAME: <u>Pauline Schulte</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes</u> <u>WW I</u>				16. SOCIAL SECURITY NO. <u>220-12-6893</u>		17. INFORMANT & ADDRESS: <u>Clin. Rec. Vet. Adm. Hospital, Ft. Howard, Md.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>CARCINOMA LUNG</u>						UNKNOWN	
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>10-13-52</u>		19B. MAJOR FINDINGS OF OPERATION: <u>Thoracotomy - Transitional cell carcinoma lung.</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>VA</u> M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec. 12, 1955</u> , to <u>Dec. 19, 1955</u> , that I saw the deceased <u>and that death occurred at 8:30AM, from the causes and on the date stated above.</u>							
SIGNATURE <u>Francis G. Dickey</u>				ADDRESS <u>M.D. VAH, FORT HOWARD, MARYLAND</u>		DATE SIGNED <u>12-19-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12-24-55</u>		NAME OF CEMETERY OR CREMATORY <u>Lorraine Park</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>12-20-55</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>Frederick Cole</u>		ADDRESS <u>1913 W. Baltimore, Md.</u>	



INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial permit.

VS AISC 1-55 10M

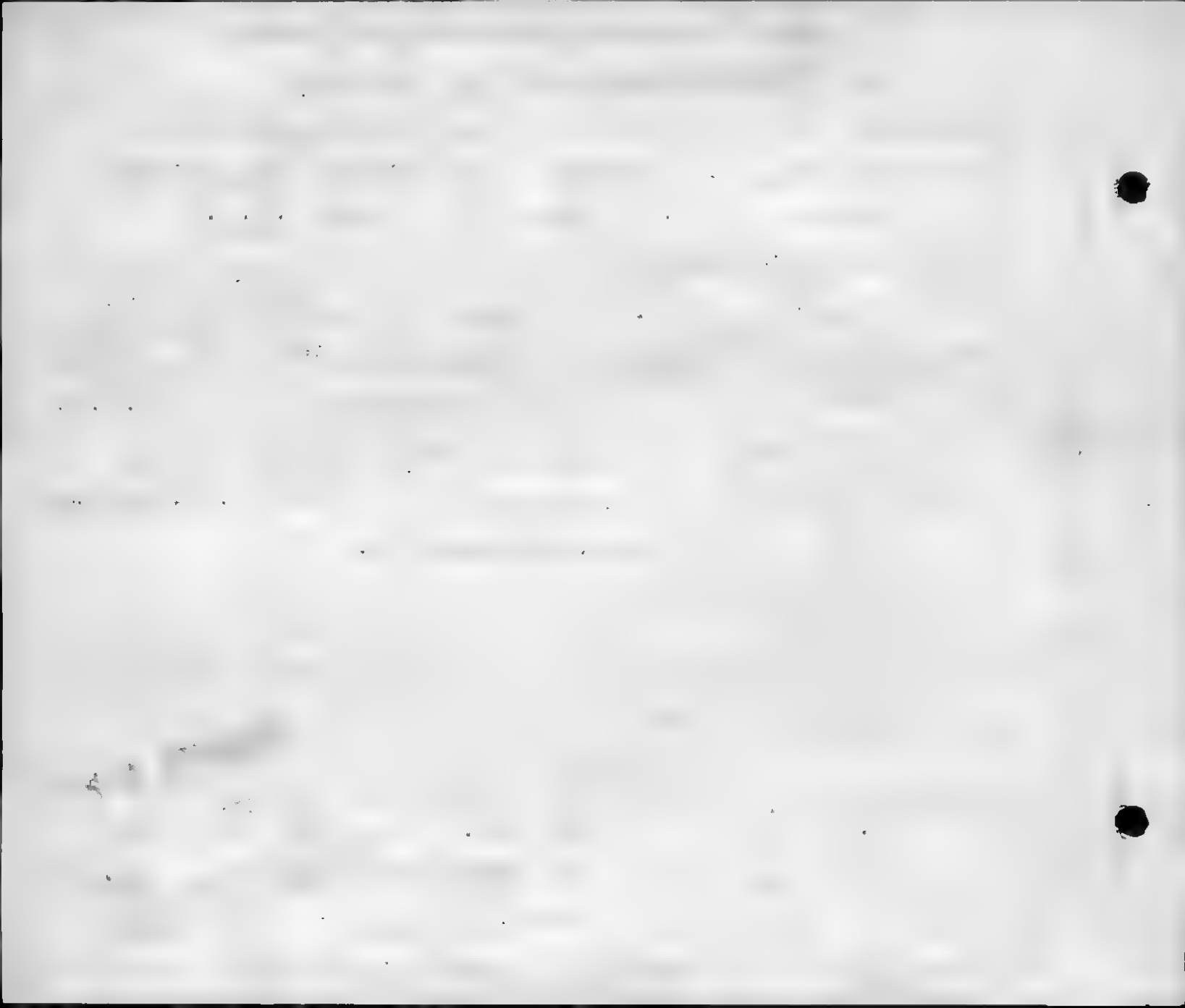
MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11564

11574 **CERTIFICATE OF DEATH**

Reg. Dist. No. 30

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>52</u> <u>Baltimore</u>		LENGTH OF STAY (in this place) <u>12 years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baldwin, R. F. D.</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>14</u> <u>Spring Grove Hospital</u>				STREET ADDRESS (if rural give location)			
3. NAME OF DECEASED (First) (Middle) (Last) <u>Albert A. Billingslea</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>December 6 19 55</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>12/13/1905</u>	9. AGE last birthday <u>50</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Contractor</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Joseph Billingslea</u>				14. MOTHER'S MAIDEN NAME <u>Lillian Roach</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Unknown</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Spring Grove Hospital</u> <u>Baltimore, 28, Maryland</u>			
18. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				19. MEDICAL CERTIFICATION			
<u>207X</u> IMMEDIATE CAUSE (A) <u>Brain tumor, type undetermined.</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July</u>, 19<u>53</u>, to <u>December</u>, 19<u>55</u>, that I last saw the deceased alive on <u>Dec. 6</u>, 19<u>55</u>, and that death occurred at <u>4 p.</u>M., from the causes and on the date stated above.							
SIGNATURE <u>Silla Wachter</u>				DATE SIGNED <u>Dec. 6, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				DATE THEREOF <u>Dec. 10, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>St. John's, Cemetery</u>	
24. REC'D BY REGISTRAR <u>DATE</u>				REGISTRAR'S SIGNATURE <u>V. E. Harris</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck, 5305 Harford Road #14</u>	
				LOCATION (City, town, or county) <u>Long Green, Maryland</u>		ADDRESS	



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL

The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11565

11575

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Baltimore		MARYLAND		STATE Maryland		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Towson 4, Maryland		8 yrs. 356 days		TOWN Baltimore		34 4	
HOSPITAL OR INSTITUTION OR STREET ADDRESS The Sheppard & Enoch Pratt Hospital				STREET ADDRESS (If rural give location)			
Towson 4, Maryland				3301 St. Paul Street ✓			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) (Middle) (Last) Lucy Forney Bittering				(Month) (Day) (Year) December, 9, 19 55			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
F	W	Single	August 29, 1859	96 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Former Deaconess				Cleveland, Ohio		U.S.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Joseph Raugher Fittinger, DD				Catherine Nace Forney			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
No				Mr. Philip N. Forney (cousin) 214 E. Walnut St., Hanover, Pa.			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				15. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
331X IMMEDIATE CAUSE (A) Cerebral Hemorrhage						3 days	
ANTECEDENT CAUSE(S) DUE TO (B) Generalized Arteriosclerosis						10 yr +	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH				Senile Psychosis		10 yr +	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Dec 12, 19 46 to Dec 9, 19 55, that I last saw the deceased alive on Dec 9, 19 55, and that death occurred at 11:40 PM, from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
W. H. Elgin				M.D. Sheppard & Pratt Hosp. Towson Md		12/10/55	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		12/12/55		Fox Creek		Hanover, Pa York	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE Dec. 13, 1955		Mabel C. Gray		Rodrick Bucher		Hanover	

U. S. A.

13 15 1955

RECEIVED

11576

CERTIFICATE OF DEATH

Reg. Dist. No.

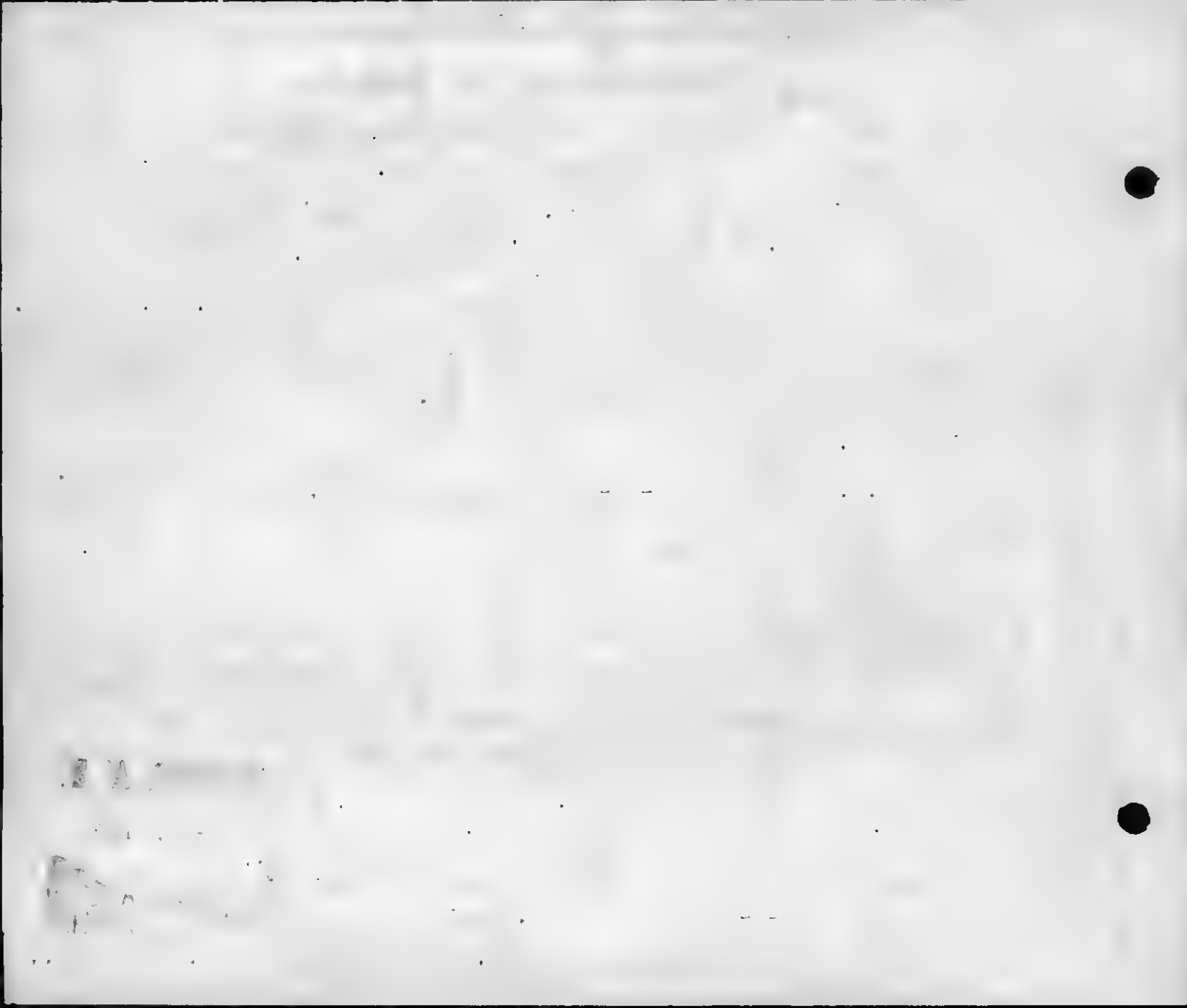
1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Baltimore		MARYLAND		STATE Md.		COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN Franklintown		35 Yrs.		TOWN Franklintown			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 1512 St. Agnes Lane				STREET ADDRESS (If rural give location) 1512 St. Agnes Lane			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) Clarence Carey Blackburn				4. DATE OF DEATH (Month) (Day) (Year) Dec. 2, 19 55.			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH March 20, 1894		9. AGE last birthday 61 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William W. Blackburn				14. MOTHER'S MAIDEN NAME Effie May Nicholson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) Yes		16. SOCIAL SECURITY NO. 216-10-5983		17. INFORMANT & ADDRESS Katherine M. Blackburn 1512 St. Agnes Lane			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				6 mos.			
181X IMMEDIATE CAUSE (A) Carcinoma of Bladder							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. Not while at work <input type="checkbox"/> While at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Aug. 1955 , to Dec. 2, 19 55 , that I last saw the deceased alive on Dec. 22, 19 55 , and that death occurred at 11 A.M. from the causes and on the date stated above.							
SIGNATURE [Signature]				ADDRESS (Street, city, town, state) 1 Mallow Hill Ave., Baltimore 29, Md.		DATE SIGNED 12/2/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 12-6-1955		NAME OF CEMETERY OR CREMATORY New Balto. National		LOCATION (City, town, or county) (State) Baltimore, Md.	
24. REC'D BY REGISTRAR [Signature]		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE G. Howard Strong		ADDRESS 3207 W. North Ave.,	
DATE DEC 5 1955							

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

MS A15C 1-55 10M



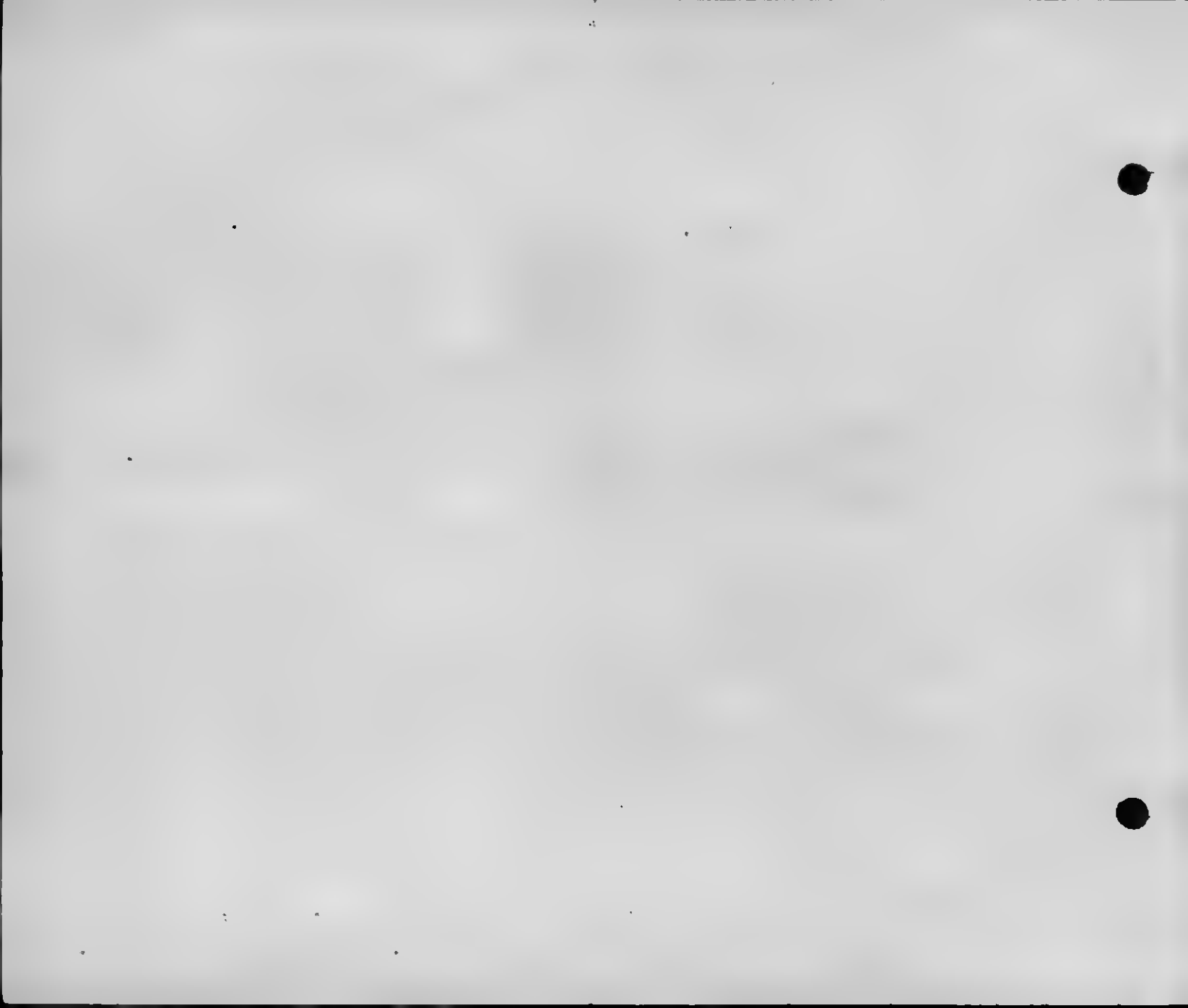
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

11546
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11567

No. 4

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
TOWN <u>Turner Station</u>		<u>3 months</u>		TOWN <u>Turner Station</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>667 Avondale Rd.</u>				STREET ADDRESS <u>667 Avondale Rd.</u> (If rural, give location)			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>LEROY</u> <u>BLACKWELL</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Dec. 7,</u> <u>19 5</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH: <u>9/21/55</u>	9. AGE last birthday: <u>3 mos.</u>		IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.) <u>3 mos.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Eddie Blackwell</u>				14. MOTHER'S MAIDEN NAME: <u>Cersenia Mitchell</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>Eddie Blackwell</u> <u>667 Avondale Rd.</u>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
<u>371.2</u> Immediate cause (a)..... <u>Aspiration of vomitus</u> DUE TO Antecedent cause(s) (b)..... <u>otitis media</u> Diseases or conditions, if any, giving rise to the above cause DUE TO stating <u>underlying cause last</u> (c).....							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION: <u>2</u>		19b. MAJOR FINDING OF OPERATION:					20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County)		(State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , <u>Accident</u> <input type="checkbox"/> , <u>Suicide</u> <input type="checkbox"/> , <u>Homicide</u> <input type="checkbox"/> , <u>Undetermined cause</u> <input type="checkbox"/> .							
SIGNATURE <u>R. Fisher</u>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>12/7/55</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>					
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>12/9/55</u>		NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn</u>		LOCATION (City, town, or county) (State) <u>Mt. Winans, Maryland</u>	
DATE REC'D BY LOCAL REG. <u>12-8-55</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR ADDRESS <u>Charles R. Law</u> <u>802-04 Madison Ave.</u>			



11577

11568

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

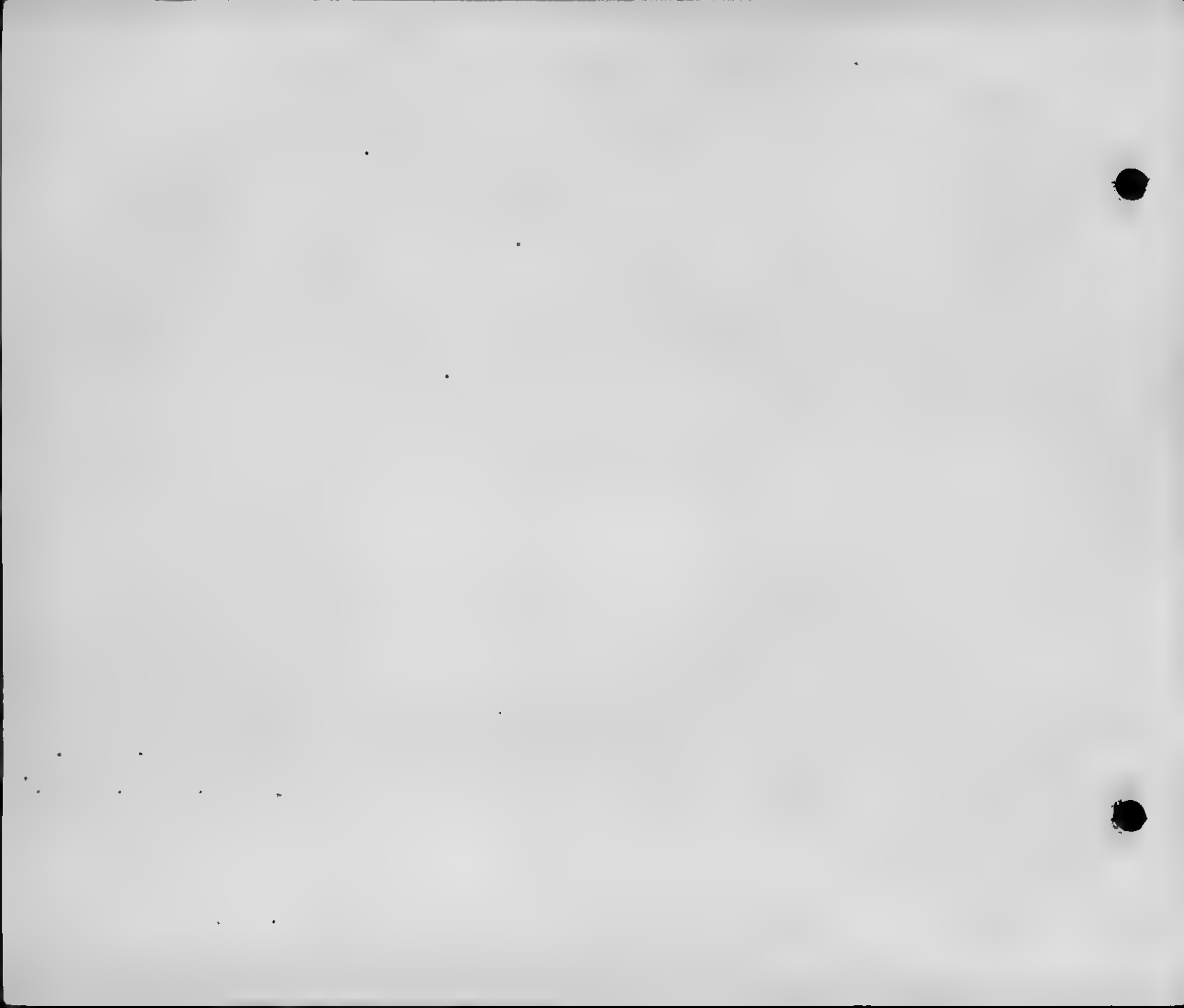
No. 3

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Baltimore	MARYLAND	STATE Md.	COUNTY Baltimore
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Loch Raven	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town) TOWN Towson 4	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Cub Hill & Cromwell Bridge Rds.		STREET ADDRESS (If rural, give location) 8514 Chestnut Oak Road	
3. NAME OF DECEASED: (First) (Middle) (Last) (Type or Print) SHIRLEY MARIE BLIEL		4. DATE OF DEATH (Month) (Day) (Year) 12 7 19 55	
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: April 4, 1931
9. AGE last birthday: 24 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Secretary		10b. KIND OF BUSINESS OR INDUSTRY: University	
11. BIRTHPLACE (State or foreign country): Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: Joseph Frank Beyer		14. MOTHER'S MAIDEN NAME: Anna Catherine Busch	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) no		16. SOCIAL SECURITY No.: Mrs. Viola McElvaney-8514 Chestnut Oak	
17. INFORMANT & ADDRESS:			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
Immediate cause (a) Gunshot wound of chest involving heart		
Antecedent cause(s) (b) Massive hemothorax		
Diseases or conditions, if any, giving rise to the above cause DUE TO		
stating underlying cause last (c)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
19a. DATE OF OPERATION: 12/7/55	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY car	21c. (City or town) (County) (State) Cub Hill & Cromwell Bridge Rds. Balto.
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY 12 7 55 M.	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? Shot self in chest, with .22 cal. rifle. Md.
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		
SIGNATURE William J. Lickner		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12/8/55 DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. 12/8/55
23. BURIAL, CREMATION, REMOVAL (Specify): Burial	DATE THEREOF 12/10/55	NAME OF CEMETERY OR CREMATORY Western Cem.
LOCATION (City, town, or county) (State) Balto., Md.	24. FUNERAL DIRECTOR Wm. J. Lickner & Sons - Balto. 17	
DATE REC'D BY LOCAL REG 12-9-55	REGISTRAR'S SIGNATURE Wm. J. Lickner	ADDRESS md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11578

CERTIFICATE OF DEATH

11569

30

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTIMORE</u>		STATE <u>MARYLAND</u>		COUNTY <u>BALTIMORE</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		LENGTH OF STAY (in this place) <u>1 YEAR</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>607 ALdershot Road</u>		STREET ADDRESS (If rural give location) <u>607 ALdershot Road</u>					
3. NAME OF DECEASED (Type or Print) <u>MARY ANNA ULczycki BOSAK</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>DEC. 3, 1955</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOW</u>	8. DATE OF BIRTH <u>Nov. 3, 1883</u>	9. AGE last birthday <u>72</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DOMESTIC</u>		11. BIRTHPLACE (State or foreign country) <u>POLAND</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>UNKNOWN WAZNALIS</u>				14. MOTHER'S MAIDEN NAME <u>ANNA MALENKAUICH</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS <u>FRANK ULCZYCKI 607 ALdershot Rd</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
1. IMMEDIATE CAUSE (A) <u>331X</u>				<u>Cerebral Hemorrhage</u>			
2. ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertension</u>							
3. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>U</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb 2, 1959</u> to <u>Dec 3, 1955</u>, that I last saw the deceased alive on <u>Dec 3, 1955</u>, and that death occurred at <u>9:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Milton Siscovich</u>				ADDRESS (Street, city, town, state) <u>1429 W. Fayette</u>		DATE SIGNED <u>12/5/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>12-6-55</u>		NAME OF CEMETERY OR CREMATORY <u>NEW CATHEDRAL</u>		LOCATION (City, town, or county) (State) <u>BALTIMORE MD.</u>	
24. REC'D BY REGISTRAR <u>12-6-55</u>		REGISTRAR'S SIGNATURE <u>J. E. Harris</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>GEO. L. Schwalb</u>		ADDRESS <u>2101 Frederick Ave</u>	

1955

1955

1955

11570

11579

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Catonsville</u>		<u>7 days</u>		TOWN <u>Catonsville</u>		<u>5-</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>200 Bloomsbury Avenue</u>				STREET ADDRESS (If rural give location) <u>200 Bloomsbury Avenue</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>ROSA</u> (Middle) <u>CECILIA</u> (Last) <u>BROSENNE</u>				(Month) <u>Dec.</u> (Day) <u>11</u> (Year) <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	10. IF UNDER 1 YEAR		
<u>Female</u>	<u>White</u>	<u>Single</u>	<u>June 7, 1886</u>	<u>69</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY?		
<u>Retail sale of groceries (own store)</u>			<u>Maryland</u>		<u>U. S. A.</u>		
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Christian P. Brosenne</u>				<u>Margaret M. Bach</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>216-92-7108</u>		<u>Miss Catherine M. Brosenne Catons. Md.</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				<u>Leukemia (Acute)</u>			
204.3 IMMEDIATE CAUSE (A)				<u>6 weeks</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				<u>5 Mps</u>			
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work Not while at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12/14/55</u> , 19 <u>55</u> , to <u>12/11</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12/10</u> , 19 <u>55</u> , and that death occurred at <u>11.0</u> M, from the causes and on the date stated above.							
SIGNATURE				DATE SIGNED			
<u>James H. Lutzinger</u>				<u>4123 Frederick Ave. Balt. 29 12/10/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE HEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
<u>Burial</u>		<u>12/14/55</u>		<u>St. Louis Cemetery</u>		<u>Clarksville, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>12/13/55</u>		<u>T. E. Herring</u>		<u>Easton Sons</u>		<u>Catonsville, Md.</u>	

INSTRUCTIONS

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TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C, 1-55 10M

U. S. A.

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

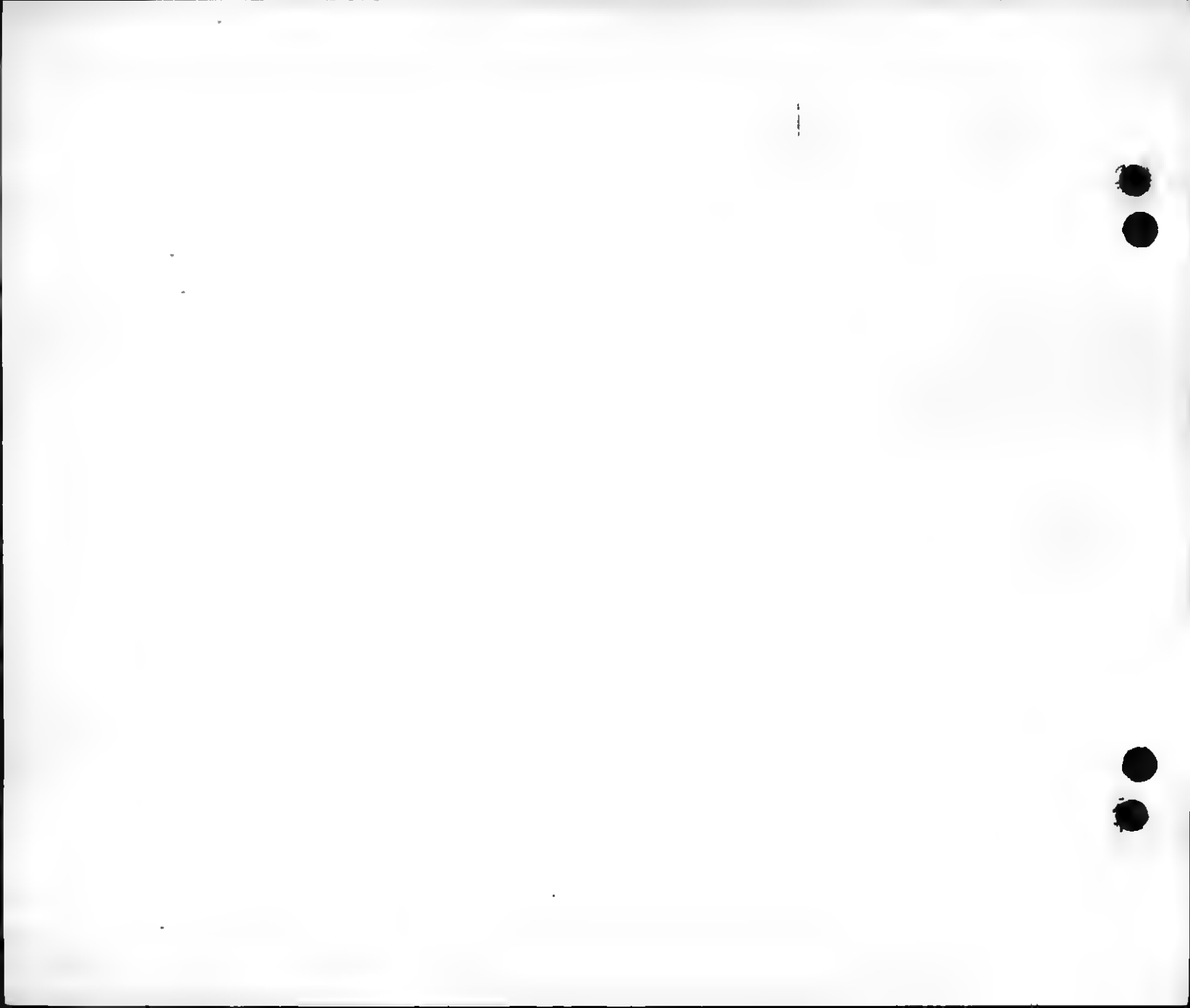
11530

CERTIFICATE OF DEATH

11571

Reg. Dist. No. 38

1. PLACE OF DEATH- COUNTY <u>Baltimore</u>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>-----</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>TOWN Rural - Ruxton</u>		LENGTH OF STAY (In this place) <u>6 weeks</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>TOWN Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sorensen Nursing Home</u>				STREET ADDRESS (If rural, give location) <u>1610 Mt. Royal Ave.</u>	
3. NAME OF DECEASED (Type or Print) <u>Miss Nora L. Brown</u>		(First) (Middle) (Last)		4. DATE OF DEATH (Month) (Day) (Year) <u>Dec. 25, 1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Unknown</u>	9. AGE last birthday <u>About 77 yrs.</u>	If under 1 year Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>	
13. FATHER'S NAME <u>James Brown</u>		12. CITIZEN OF WHAT COUNTRY? <u>-----</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>-----</u>		17. INFORMANT <u>Mrs. Charles Brown</u>	
18. MEDICAL CERTIFICATION					
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Myocarditis chronic with fibrillation</u>					<u>10 days</u>
Antecedent cause(s) (b) <u>Myocardial hypertrophy with failure</u>					<u>5 years</u>
(c) <u>Hypotension arterial</u>					<u>5 years</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Advancing years</u>					
19a. DATE OF OPERATION <u>no operation</u>		19b. MAJOR FINDINGS OF OPERATION <u>no operation</u>			20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE <u>none</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY <u>none</u>		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>none</u>		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR? <u>no injury</u>	
22. I hereby certify that I attended the deceased from <u>Nov. 10, 1955</u> , to <u>Dec. 25, 1955</u> , that I last saw the deceased alive on <u>Dec. 25, 1955</u> , and that death occurred at <u>9:40</u> a.m., from the causes and on the date stated above.					
SIGNATURE <u>James Graham Martin</u>		(Degree or title)		ADDRESS <u>516 Cathedral Street</u>	
DATE SIGNED <u>12-26-55</u>					
23. BURIAL, CREMATION OR REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>12/29/55</u>		NAME OF CEMETERY OR CREMATORY <u>Cathedral</u>	
LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>					
DATE REC'D BY LOCAL REG. <u>12-27-55</u>		REGISTRAR'S SIGNATURE <u>(Signature)</u>		24. FUNERAL DIRECTOR <u>H. H. Mears and Son - 805 N. Calvert St.</u>	



11531

CERTIFICATE OF DEATH

Reg. Dist. No. 3

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>				STATE <u>MD.</u> COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>52 TOWN Catonsville</u>				CITY (If outside corporate limits, write RURAL and give nearest town) <u>50 yrs Baltimore</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>90 House in Pines 16 Rusting Ave.</u>				STREET ADDRESS (If rural give location) <u>4628 Rokeby Rd</u>			
3. NAME OF DECEASED (Type or Print) <u>Olive Buckingham</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Dec. 6/55</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>March 4, 1883</u>	9. AGE (last birthday) yrs. <u>72</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Isaac Anthony</u>				14. MOTHER'S MAIDEN NAME <u>Susan Gouwin</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mrs Edward Jones, 4628 Rokeby Rd</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				4. 4. 4.			
442X IMMEDIATE CAUSE (A) <u>Cerebral Thrombosis</u>				10 3/4			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Ch. Hypertensive Cardio-Vasc. Renal Disease</u>				6 3/4			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Rheumatoid Arthritis</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10-9</u> , 19 <u>57</u> , to <u>12-6</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12-6</u> , 19 <u>55</u> , and that death occurred at <u>8:15</u> P.M. from the causes and on the date stated above.							
SIGNATURE <u>William H. Gallager</u>				ADDRESS (Street, city, town, state) DATE SIGNED <u>M.D. 6209 Frederick Rd. Baltimore 28, 12/8/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Dec. 9/55</u>		NAME OF CEMETERY OR CREMATORY <u>London Park</u>		LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
24. REC'D BY REGISTRAR <u>DATE - 12-10-55</u>		REGISTRAR'S SIGNATURE <u>V. E. Garry</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Harriet A. White</u>		ADDRESS <u>2000 N. Ave.</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M



11532

CERTIFICATE OF DEATH

11573

Reg. Dist. No. 28

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Ruxton</u>		LENGTH OF STAY (In this place) <u>4 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sorrenson Nursing Home</u> <u>7912 Ruxway Road</u>				STREET ADDRESS (If rural give location) <u>54 Franklinton Road</u>			
3. NAME OF DECEASED (Type or Print) (First) <u>WILLIAM</u> (Middle) <u>HENRY</u> (Last) <u>BULL</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Dec. 27, 1955</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>Aug. 22, 1861</u>	9. AGE last birthday <u>94</u> yrs.	IF UNDER 1 YEAR Months <u>4</u> Days <u>4</u>		IF UNDER 24 HRS. Hours <u>4</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>--</u>		11. BIRTHPLACE (State or foreign country) <u>Frederick, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Amby Bull</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Rutledge</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT & ADDRESS <u>54 Franklinton Road</u> <u>Mrs. Louise Lotz, Road</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
199.1 IMMEDIATE CAUSE (A) <u>Malignancy metastasis</u>						<u>3 years</u>	
ANTECEDENT CAUSE(S) DUE TO <u>cardiac</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>Valvular disease chronic mitral</u>						<u>5 years</u>	
(C) <u>Myocarditis chronic</u>						<u>5 years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Myocardial hypertrophy.</u>						<u>5 years</u>	
19a. DATE OF OPERATION <u>none</u>		19b. MAJOR FINDINGS OF OPERATION <u>none</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>no injury</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>none</u>		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>no injury</u>			
22. I hereby certify that I attended the deceased from <u>Dec. 22, 1955</u> , to <u>Dec. 26, 1955</u> , that I last saw the deceased alive on <u>Dec. 23, 1955</u> , and that death occurred at <u>11:30</u> M., from the causes and on the date stated above.							
SIGNATURE <u>James Graham Martin</u>				ADDRESS (Street, city, town, state) <u>510 Cathedral Street</u>		DATE SIGNED <u>Dec 28, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>burial</u>		DATE THEREOF <u>12-30-55</u>		NAME OF CEMETERY OR CREMATORY <u>Asbury M. E. Church</u>		LOCATION (City, town, or county) (State) <u>Reisterstown, Maryland</u>	
24. REC'D BY REGISTRAR <u>1356</u>		REGISTRAR'S SIGNATURE <u>Mabel Gray</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm Cook-Blight, Inc.</u>		ADDRESS <u>6009 HARTFORD</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 11 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 153C 1-55 70M

UNITED STATES

JAN

1961

11583

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Pennsylvania</u>	
CITY (If outside corporate limits, write RURAL OR TOWN) <u>Pikesville</u>	LENGTH OF STAY (in this place) <u>10 days</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Hughesville, Pa. 758</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>60</u>		STREET ADDRESS (If rural give location) <u>Rd. #4</u>	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) <u>George Hill</u>	(Middle) <u>Burgett</u>	(Last) <u>Burgett</u>	DATE OF DEATH: <u>Dec. 7 1955</u>
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>widowed</u>	8. DATE OF BIRTH: <u>June 30, 1874</u>
9. AGE last birthday: <u>81</u> yrs.		10. AGE last birthday: IF UNDER 1 YEAR Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Farmer</u>		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <u>Muncy, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Abraham Burgett</u>		14. MOTHER'S MAIDEN NAME: <u>Mary Poust</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT & ADDRESS: <u>Mr. James Reid, Pikesville</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
331X IMMEDIATE CAUSE (A) <u>Cerebral Vascular Accident</u>		<u>10 days</u>	
ANTECEDENT CAUSE (B) <u>Hypertension</u>		<u>5 yrs.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>260X</u> (C) <u>Diabetes Mellitus</u>		<u>5 yrs.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Nov. 28, 1955</u> , to <u>Dec. 7, 1955</u> , that I last saw the deceased alive on <u>Dec. 6, 1955</u> , and that death occurred at <u>6:30 A.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>James A. Miller, Jr.</u>		DATE SIGNED <u>Dec. 7, 1955</u>	
ADDRESS <u>Pikesville, Md.</u>		M. D. <u>Pikesville, Md.</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Dec. 10, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Pleasant Hill</u>		LOCATION (City, town, or county) (State) <u>Hughesville, Pa.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Dec. 10, 1955</u>		REGISTRAR'S SIGNATURE <u>Dorothy A. Newell</u>	
24. FUNERAL DIRECTOR'S ADDRESS <u>Frank H. Newell, Pikesville</u>			

MARGIN RESERVED FOR BINDING

U.S. AIR FORCE

100-100000

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11575

11584 CERTIFICATE OF DEATH

Reg. Dist. No. 3

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		LENGTH OF STAY (in this place) <u>15 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>		<u>3 Vol. 4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>16 Fustling Ave.</u>				STREET ADDRESS (If rural give location) <u>27 N. PORT ST.</u>			
3. NAME OF DECEASED (Type or Print) <u>George</u> (First) <u>E</u> (Middle) <u>Caltrider</u> (Last)				4. DATE OF DEATH (Month) <u>12</u> (Day) <u>26</u> (Year) <u>1955</u>			
5. SEX <u>711</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>5/5/84</u>	9. AGE last birthday <u>71</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TAVERN OWNER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>TAVERN</u>		11. BIRTHPLACE (State or foreign country) <u>BALTO. MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>CHARLES CALTRIDER</u>				14. MOTHER'S MAIDEN NAME <u>LOUISA FCE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT & ADDRESS <u>MRS NAOMI P. CALTRIDER</u>		<u>27 N PORT ST.</u>	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Metastatic Carcinoma of Esophagus</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 mo.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Primary Carcinoma of Larynx</u>						<u>2 yr</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12/12</u> , 19 <u>55</u> , to <u>12/26</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12/26</u> , 19 <u>55</u> , and that death occurred at <u>4:30 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Wilmer K. Gallagher</u>				ADDRESS (Street, city, town, state) <u>M.D. 6209 Frederick Ave. Balt. 28, Md.</u>		DATE SIGNED <u>12/26/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12/29/55</u>		NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cem.</u>		LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
24. REC'D BY REGISTRAR <u>Dec. 29, 1955</u>		REGISTRAR'S SIGNATURE <u>T. E. Harris</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John A. Moran</u>		ADDRESS <u>3000 E. Balto. St.</u>	

per M. Harris

3 A 01 2

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1944
12 15 1944
12 15 1944

11535

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

COUNTY Baltimore

MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town) Towson 4, Maryland

LENGTH OF STAY (in this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS The Sheppard & Enoch Pratt Hospital
Towson 4, Maryland

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland

COUNTY

CITY (If outside corporate limits, write RURAL and give nearest town) Baltimore

(If rural give location)

ADDRESS 2114 Presbury Street

3. NAME OF DECEASED:

(First)

Florine

(Middle)

Schwob

(Last)

Caplan

4. DATE OF DEATH:

(Month)

(Day)

(Year)

December 11, 1955

5. SEX:

F

6. COLOR OR RACE:

W7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow

8. DATE OF BIRTH:

May 17, 1889

9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.

66 yrs.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY

at home

11. BIRTHPLACE (State or foreign country):

France

12. CITIZEN OF WHAT COUNTRY?

U. S.

13. FATHER'S NAME:

Harry Schwob

14. MOTHER'S MAIDEN NAME:

Esther Wormer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

No

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

Simon Schwob

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

422.1
Immediate cause(a) Chronic myocarditis
DUE TO Femoral embolismAntecedent causes (s)
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.(b) Generalized arteriosclerosis
DUE TO

(c)

Interval Between Onset And Death

5 yr +
1 wk.
5 yr +

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Paranoid Schizophrenia Meningioma15 yr +

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

AUTOPSY?

Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 13, 1943 to Dec 11, 1955, that I last saw the deceasedalive on Dec 10, 1955, and that death occurred at 2:30 AM, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

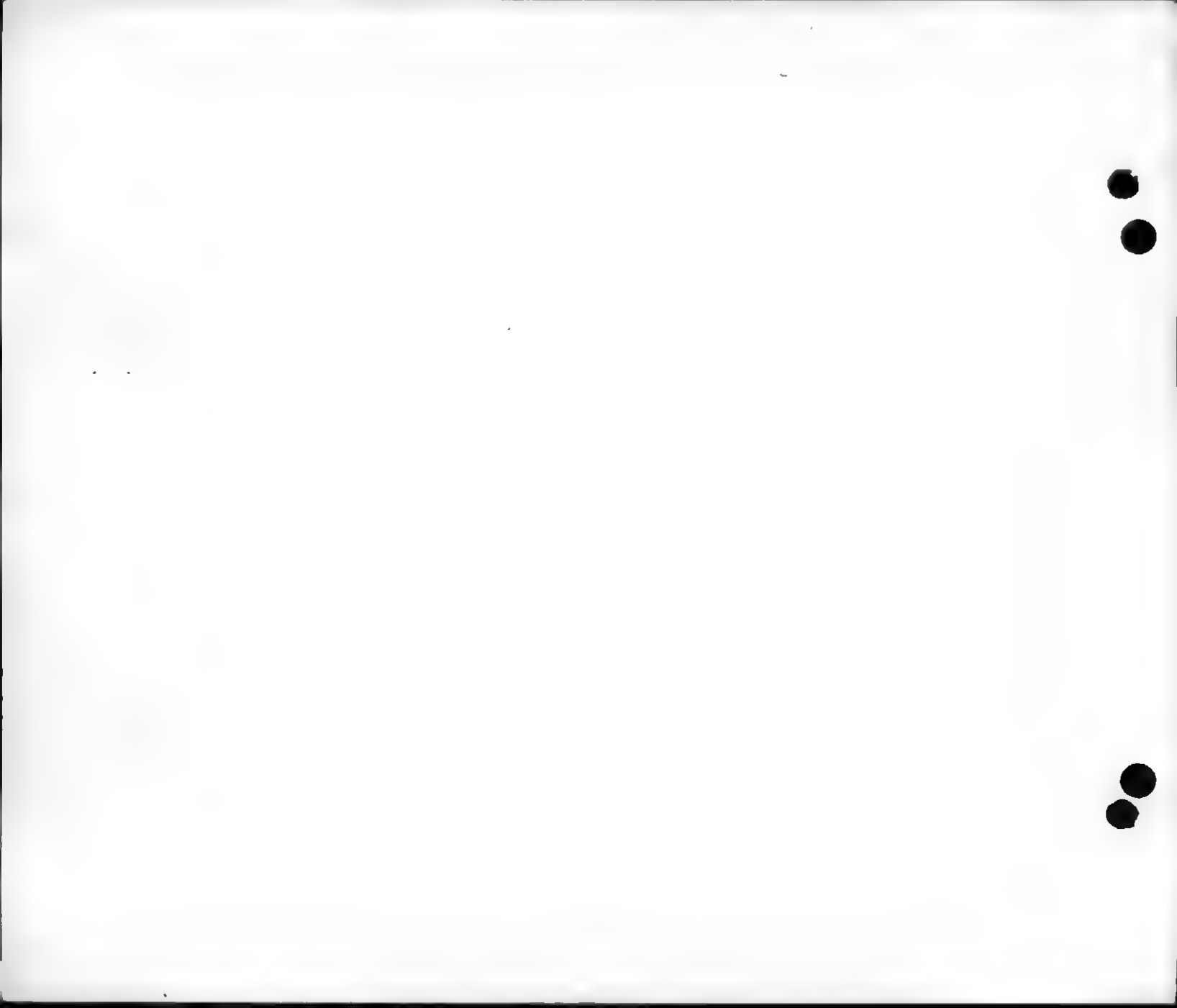
FUNERAL DIRECTOR

ADDRESS

Dec 14, 1955W. E. Elgin, M.D., Towson, Md.THE SHEPPARD & ENOCH PRATT HOSPITAL2/12/55Dec 14, 1955W. E. Elgin, M.D., Towson, Md.THE SHEPPARD & ENOCH PRATT HOSPITAL2/12/55

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



11536

CERTIFICATE OF DEATH

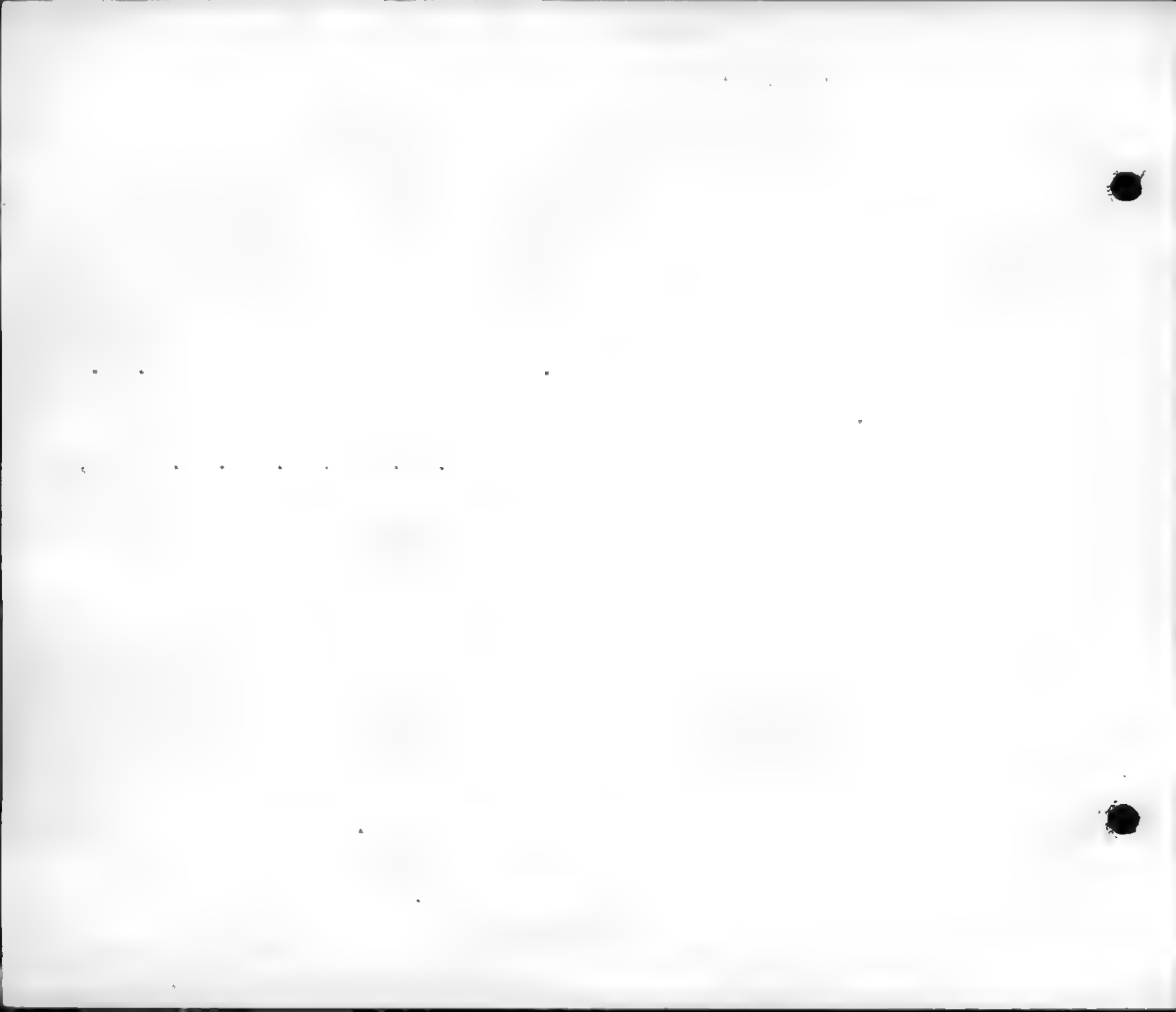
Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Fort Howard</u>	LENGTH OF STAY (in this place) <u>52 days</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>50 Veterans Administration Hospital</u>		STREET ADDRESS (If rural give location) <u>689 W. Mulberry Street</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <u>CHARLES</u>	(Middle) <u>(NMI)</u>	(Last) <u>CARTER</u>	(Month) <u>December</u> (Day) <u>3</u> (Year) <u>1955</u>
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>8/28/96</u>
9. AGE last birthday: <u>59</u> yrs.		10. BIRTHPLACE (State or foreign country): <u>Granite, Maryland</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Chauffeur</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Willis J. Carter</u>		14. MOTHER'S MAIDEN NAME: <u>Mary Morse</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes</u> <u>NW I</u>		16. SOCIAL SECURITY NO. <u>213-14-0882</u>	
17. INFORMANT & ADDRESS: <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md</u>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>CARCINOMA OF ESOPHAGUS</u>		<u>7 Months</u>	
ANTECEDENT CAUSE (S)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Oct 12</u> , 1955, to <u>Dec. 3</u> , 1955, and that death occurred at 7:20 AM, from the causes and on the date stated above.			
SIGNATURE <u>GEORGE LEENER</u>		DATE SIGNED <u>12/3/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12/7/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>12-7-55</u>		24. FUNERAL DIRECTOR <u>Halstead Funeral Home</u> ADDRESS <u>918 Druid Hill Ave Balto. Md</u>	

MARGIN RESERVED FOR BINDING

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A13C 1-55 10M

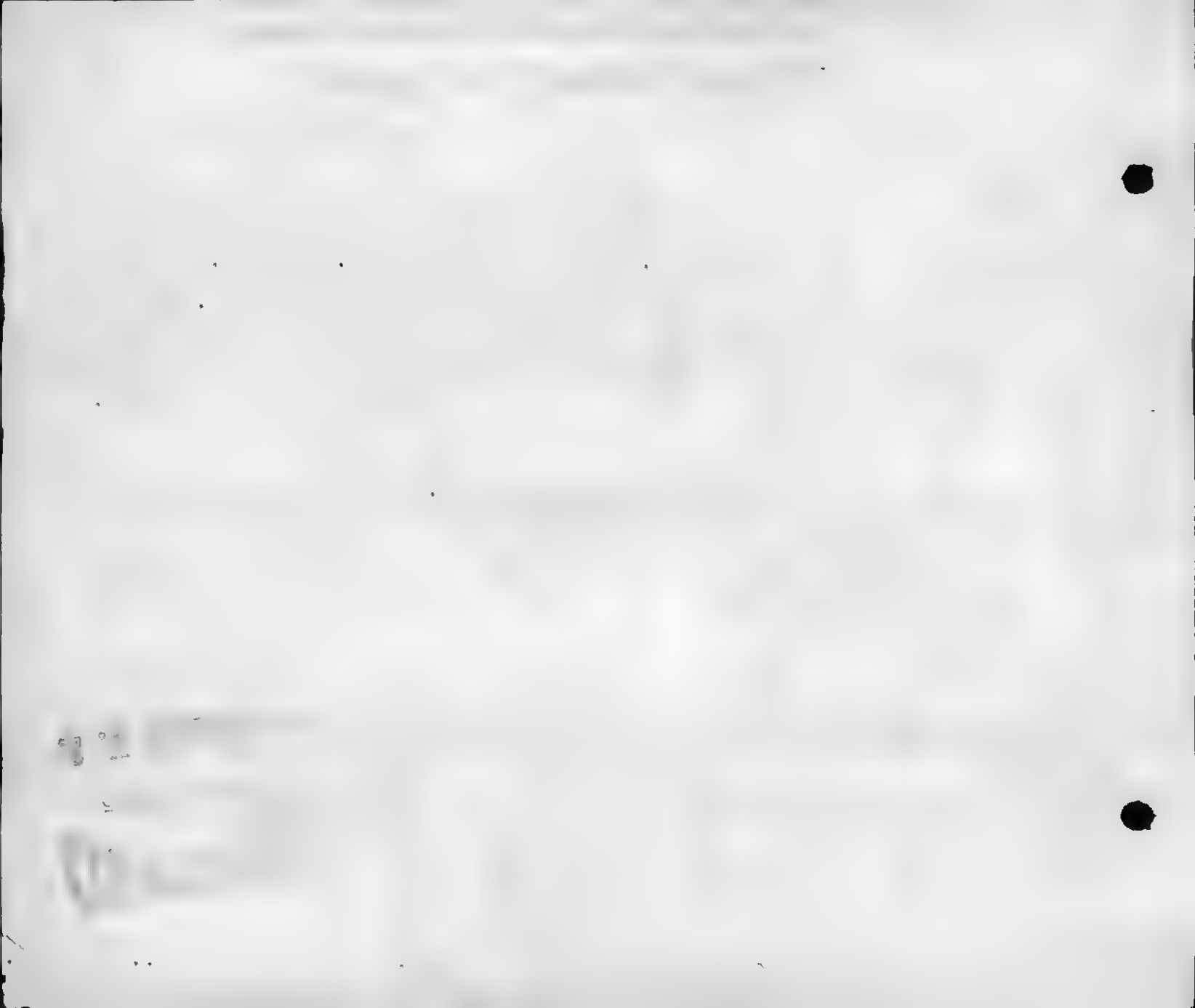
MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11578

11587 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		STATE <u>Maryland</u>		COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Towson</u>		LENGTH OF STAY (In this place) <u>4 years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore City</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Mercy Villa</u> <u>6400 Bellona Ave.</u>		STREET ADDRESS (If rural give location) <u>811 St. Paul St.</u>					
3. NAME OF DECEASED (Type or Print) <u>Sara Daingerfield Carter</u>				4. DATE OF DEATH Dec. <u>24</u> , 19 <u>55</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>October 4, 1874</u>	
9. AGE last birthday <u>81</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Alexandria Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Reverdy Daingerfield</u>		14. MOTHER'S MAIDEN NAME <u>Effie Nickelson</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>1102 Rolandvue Ave</u> <u>Mrs. Morgan La Montagne</u>					
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				IS. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Nephritis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>years</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> A. <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec 21</u> , 19 <u>55</u> , to <u>Dec 25</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Dec 21</u> , 19 <u>55</u> , and that death occurred at <u>10:20 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Wall B. Buck</u>				DATE SIGNED <u>Dec 25</u>			
ADDRESS (Street, city, town, state) <u>18 E. Egan St Baltimore 2</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12-28-55</u>		NAME OF CEMETERY OR CREMATORY <u>Greenmount Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>	
24. REC'D BY REGISTRAR <u>Dec. 29 1955</u>		REGISTRAR'S SIGNATURE <u>Medel Gray</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Henry W. Jenkins & Sons Co.</u>		ADDRESS <u>4905 York Rd.</u>	



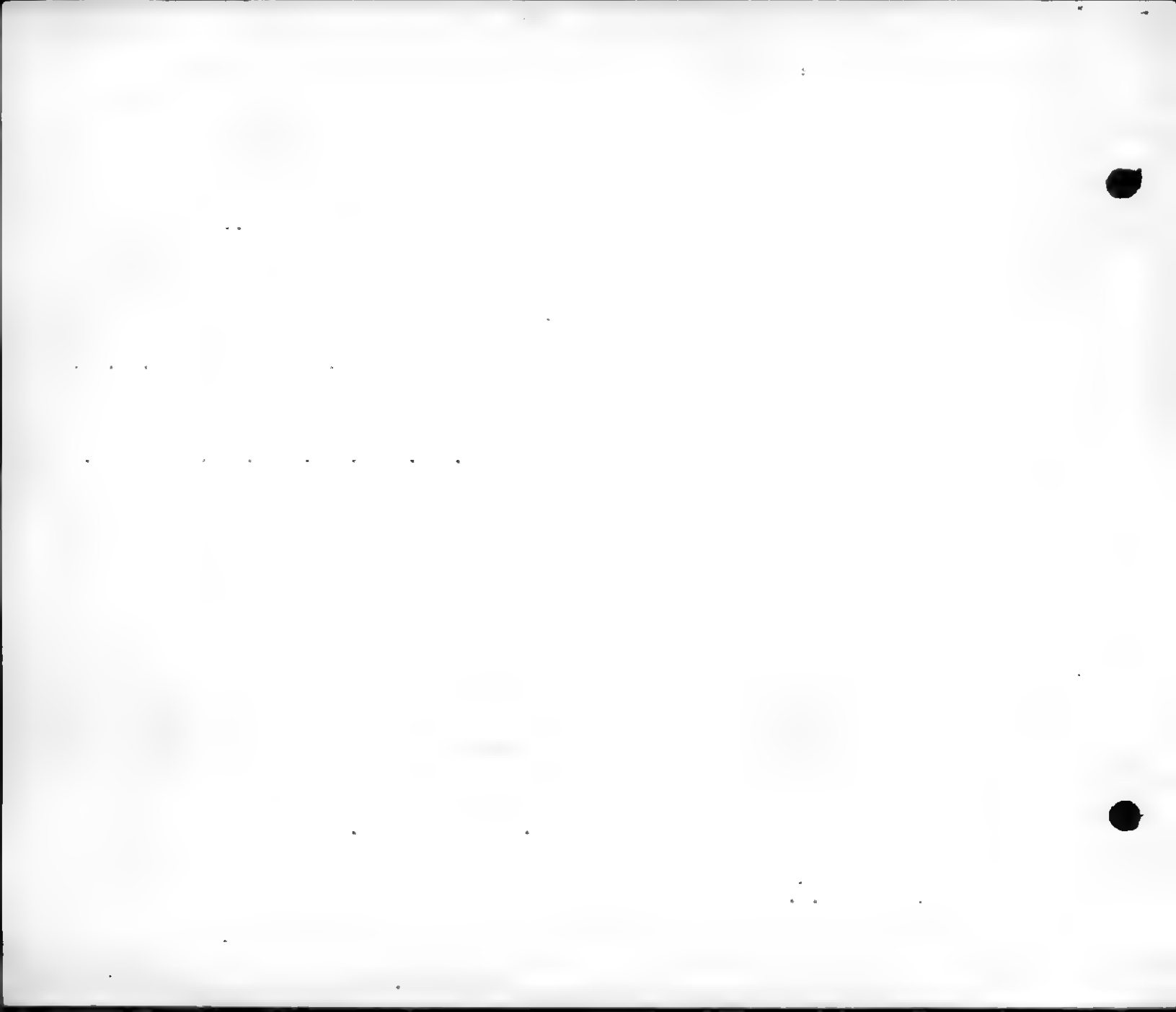
PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 11579

11538 CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <u>Baltimore</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u> TOWN <u>Fort Howard</u> LENGTH OF STAY (in this place) <u>50 days</u>			STATE <u>Maryland</u> COUNTY _____ CITY (If outside corporate limits, write RURAL and give nearest town) _____ OR TOWN <u>Baltimore</u>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>			STREET ADDRESS (If rural give location) <u>304 Laurens Street</u>		
3. NAME OF DECEASED: (First) <u>JAMES</u> (Middle) _____ (Last) <u>CHAPMAN</u>			4. DATE (Month) (Day) (Year) OF DEATH: <u>December 2, 1955</u>		
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>10-15-90</u>		9. AGE last birthday: <u>65</u> yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Janitor</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>School</u>		11. BIRTHPLACE (State or foreign country): <u>Upper Marlboro, Maryland</u>	
13. FATHER'S NAME: <u>Stephen Chapman</u>			12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes WW I</u>			16. SOCIAL SECURITY NO. <u>218-01-5522</u>		17. INFORMANT & ADDRESS: <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>
18. MEDICAL CERTIFICATION					
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>177X</u> IMMEDIATE CAUSE (A) <u>CARCINOMA OF PROSTATE WITH GENERALIZED TUMOR METASTASES</u> ANTECEDENT CAUSE (B) _____ DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) _____				INTERVAL BETWEEN ONSET AND DEATH <u>1 YEARS</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. _____					
19A. DATE OF OPERATION: _____		19B. MAJOR FINDINGS OF OPERATION _____			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) _____		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? _____	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY _____		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR? _____	
22. I hereby certify that I attended the deceased from <u>Oct. 13, 1955</u> , to <u>Dec. 2, 1955</u> , and that death occurred at <u>2:40 P.</u> M, from the causes and on the date stated above.					
SIGNATURE <u>Donald D. Mark</u>		ADDRESS <u>M. O. VAH, FORT HOWARD, MARYLAND</u> DATE SIGNED <u>12-5-55</u>			
DONALD D. MARK, M.D.					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12-7-55</u>		NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u> LOCATION (City, town, or county) <u>Baltimore, Maryland</u> (State) _____	
OATE REC'D BY LOCAL REGISTRAR <u>12-6-55</u>		REGISTRAR'S SIGNATURE <u>A. C. V.</u>		24. FUNERAL DIRECTOR <u>Charles R. Law Mortuary, 802-04 Madison Ave</u> ADDRESS <u>Baltimore Md</u>	



11539 CERTIFICATE OF DEATH

Reg. Dist. No.

43

1. NAME OF DECEASED (Type or Print) FRANCES ROBERTA CLAYTON			2. DATE OF DEATH 12/20/55		
3. PLACE OF DEATH: A. Baltimore City, Maryland BALTIMORE, MD			4. USUAL RESIDENCE (Where deceased lived 1 if institution; residence before admission) A. STATE Maryland B. COUNTY BALTIMORE		
B. FULL NAME OF (If not in hospital or institution, give street address or location) Baltimore County 14 Chesley Ave.			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) OVERLEA		
c. Length of stay in Baltimore Life			D. STREET ADDRESS (If rural, give location) 14 CHESLEY AVE		
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH March 31, 1882		9. AGE (In years last birthday) 73
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Best Mistress			10B. KIND OF BUSINESS OR INDUSTRY U.S. Post Office		11. BIRTHPLACE (State or foreign country) Baltimore, Md.
13. FATHER'S NAME Abram Wayson			14. MOTHER'S MAIDEN NAME Sarah Ann Ensor		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) No		16. SOCIAL SECURITY NO. None	17. INFORMANT ADDRESS Dorothy F. Lesher - 14 Chesley Ave.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) HODGKINS DISEASE			INTERVAL BETWEEN ONSET AND DEATH FEB 55		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DIABETES MELLITUS			10YRS.		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
10A. DATE OF OPERATION FEB 1955		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED ADENITIS		IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Feb 1955 to 12/20/55 , that I last saw the deceased alive on 12/20/55 , and that death occurred at 1:30 p.m. , from the causes and on the date stated above.					
23A. SIGNATURE Walter E. Karpman		23B. ADDRESS 4331 Harford Rd.		23C. DATE SIGNED 12/20/55	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE Dec. 31, 1955		24C. NAME OF CEMETERY OR CREMATORY Basley Methodist	
24D. LOCATION (City, town, or county) (State) Sparks - Baltimore County Md.		25. FUNERAL DIRECTOR ADDRESS Lansahn Funeral Home - 7401 Belair Rd.			
DATE RECEIVED BY LOCAL REGISTRAR Dec. 29-1955		REGISTRAR'S SIGNATURE Mrs. M. H. Reilander			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY UNFADING INK. Every item of information should be carefully supplied. correct age is especially int. Physicians: please write the cause of death clearly and legibly.

AL CERTIFICATION

U. S. AIR FORCE



11590

CERTIFICATE OF DEATH

11581

Reg. Dist. No. 38

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL OR end give nearest town) <u>Parkville</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL end give nearest town) <u>Parkville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>9404 Fullerdale Avenue</u>				STREET ADDRESS (If rural give location) <u>9404 Fullerdale Avenue</u>			
3. NAME OF DECEASED (Type or Print) <u>Mr. William F. Coffey</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>December 13th 1955</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>Nov. 17, 1889</u>	9. AGE last birthday <u>66</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Standard Oil Co.</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mrs. Margaret Coffey, 9404 Fullerdale</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
501. IMMEDIATE CAUSE (A) <u>Bestial enteric hemorrhage</u>				<u>6 hours</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Portal cirrhosis</u>				<u>3 years</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 14, 1955</u> , to <u>Dec 13, 1955</u> , that I last saw the deceased alive on <u>Dec 13, 1955</u> , and that death occurred at <u>12:40 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>John A. M. Bacon</u> M.D.				DATE SIGNED <u>Dec 14 1955</u>			
23. BURIAL, CREMATION REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Dec. 17 1955</u>		NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Dr. A. M. Bacon</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck, 5305 Harford Road #14</u>			
DATE <u>Dec. 15, 1955</u>							

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CERTIFICATE OF DEATH

Reg. Dist. No. 33

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

MD-153 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Baltimore</u>			
CITY (If outside corporate limits, write RURAL or and give nearest town) <u>Rural Butler</u>		LENGTH OF STAY (in this place) <u>Life</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural Butler Md Sparks P.O.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Falls Rd</u>				STREET ADDRESS (If rural give location) <u>Falls Road</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Howard Reynolds Cole</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>December 21 1955</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Divorced</u>	8. DATE OF BIRTH <u>March 24 1887</u>	9. AGE last birthday <u>68</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gardner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jordan W. Cole</u>				14. MOTHER'S MAIDEN NAME <u>Katherine Curtis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes/ no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT & ADDRESS <u>Mrs Raymond Lippin Sparks Md</u>			
18. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
18a. IMMEDIATE CAUSE (A) <u>Carcinoma Rectum</u>				INTERVAL BETWEEN ONSET AND DEATH <u>18 mo</u>			
18b. ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>---</u>							
18c. DUE TO (C) <u>---</u>							
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>---</u>							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION <u>---</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>---</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>---</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>---</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>---</u>			
22. I hereby certify that I attended the deceased from <u>July 1, 1954</u> , to <u>Dec 21, 1955</u> , that I last saw the deceased alive on <u>Dec 21, 1955</u> , and that death occurred at <u>8 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Joseph E. Bush</u>		M.D. <u>Hampstead Md</u>		DATE SIGNED <u>12-21-55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>12-24-55</u>		NAME OF CEMETERY OR CREMATORY <u>Mt. Zion U.B.</u>		LOCATION (City, town, or county) (State) <u>Upperco, Md.</u>	
24. REC'D BY REGISTRAR <u>---</u>		REGISTRAR'S SIGNATURE <u>Mary B. Eline</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>F. Scott Brooks</u>		ADDRESS <u>Sparks, Md.</u>	
DATE <u>12-22-55</u>							

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JAN 6
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PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

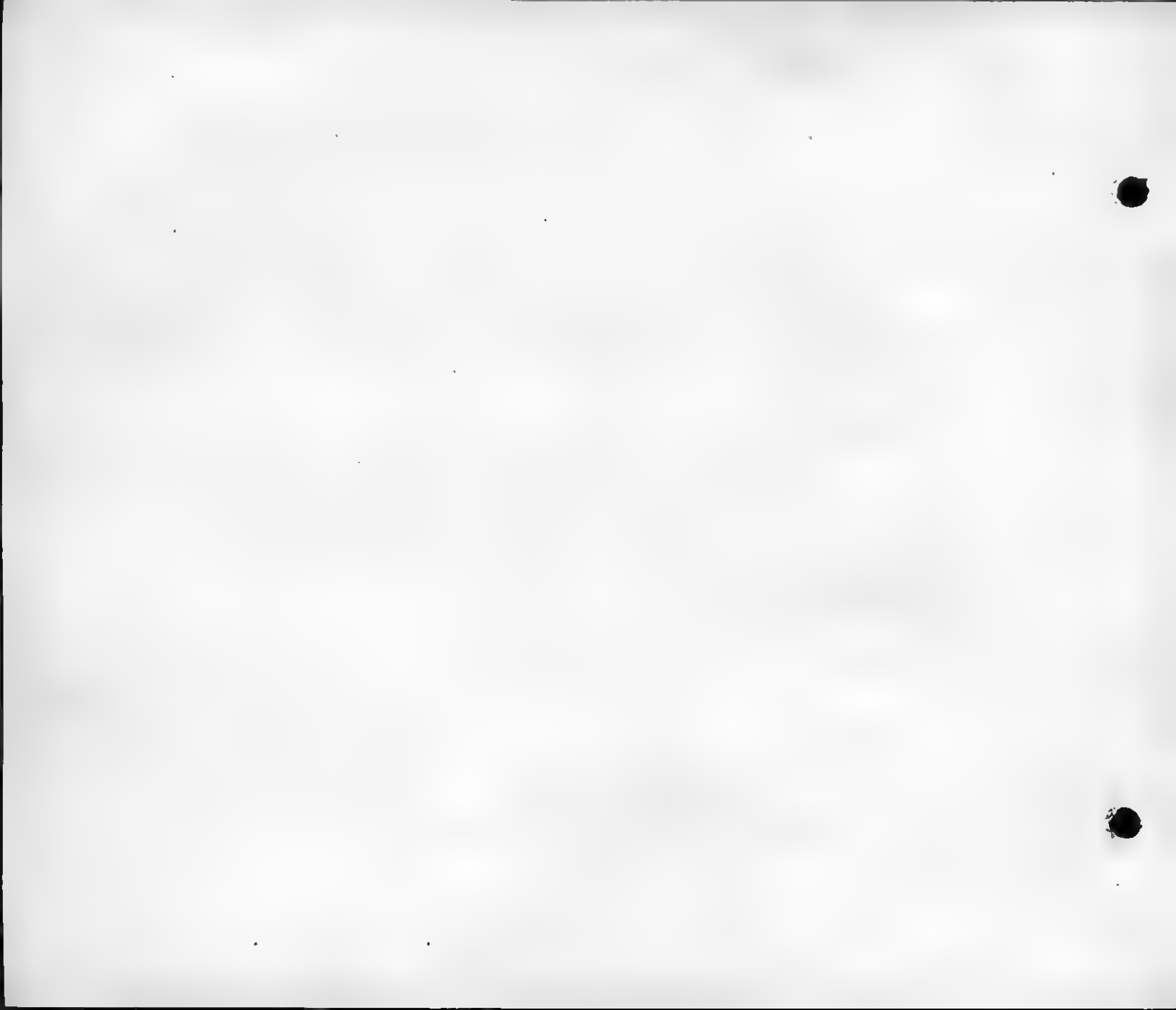
11583

11592

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Balto.		MARYLAND		STATE Md.		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) 50 TOWN Catonsville		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore 30			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 114 N. Montrose Ave.				STREET ADDRESS (If rural give location) 3947 Greenmount Ave.			
3. NAME OF DECEASED: (First) (Middle) (Last) CATHRYNE MARIE COLEBURN				4. DATE (Month) (Day) (Year) OF DEATH. Dec. 3, 19 55			
5. SEX: female	6. COLOR OR RACE: white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widowed	8. DATE OF BIRTH: Dec. 24, 1889	9. AGE last birthday 65 yrs	IF UNDER 1 YEAR Month Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife			10B. KIND OF BUSINESS OR INDUSTRY: at home		11. BIRTHPLACE (State or foreign country): Md.		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Jacob Bechtold				14. MOTHER'S MAIDEN NAME: Louisa Holzapfel			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) NO			16. SOCIAL SECURITY NO. (If Yes, give war or dates of service)		17. INFORMANT & ADDRESS: Mrs. Edw. H. Biemiller-114 Montrose Ave.		
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
180X IMMEDIATE CAUSE (A) Carcinoma Kidney							
ANTECEDENT CAUSE (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:			19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from alive on 12-3, 1955, and that death occurred at 8:15 P.M. from the causes and on the date stated above.							
SIGNATURE W. L. Ewall Jr.		M. D. 36 York Court		DATE SIGNED 12-5-55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		DATE THEREOF 12/7/55		NAME OF CEMETERY OR CREMATORY Green Mount Crem.		LOCATION (City, town, or county) (State) Balto., Md.	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		FUNERAL DIRECTOR		ADDRESS	
12-5-55		W. L. Ewall Jr.		Wm. J. Lickens & Sons - Balto. Md.		17 Md.	



1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11584

11547 CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Baltimore</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
53 TOWN <u>Dundalk</u>				TOWN <u>Dundalk</u>		53	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
00 7534 Durwood Road				7534 Durwood Road			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) (Middle) (Last)				(Month) (Day) (Year)			
EDITH L. CONNOLLY				Dec. 10, 1955			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
female	white	married	June 10, 1901	54 yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
housewife		at home		Illinois		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
William B. Scott				May Grace Green			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
---		---		Thomas J. Connolly, Jr., 7534 Durwood Rd			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						4 years	
171X IMMEDIATE CAUSE (A) <u>CARCINOMA of Cervix</u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
0							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 7/14, 1955, to 12/10, 1955, that I last saw the deceased alive on 12/10, 1955, and that death occurred at 11:00 A.M. from the causes and on the date stated above.							
SIGNATURE <u>James E. Goodman M.D.</u>				DATE SIGNED <u>809 Ca the dual St</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
burial		12/13/55		Moreland Park Cemetery		Parkville, Maryland	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DEC 13 1955		<u>Wm. P. Kelly</u>		<u>Wm. Cook Inc.</u>		1217 St. Paul Street	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

3

A

REC

RECEIVED

11548

11548
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

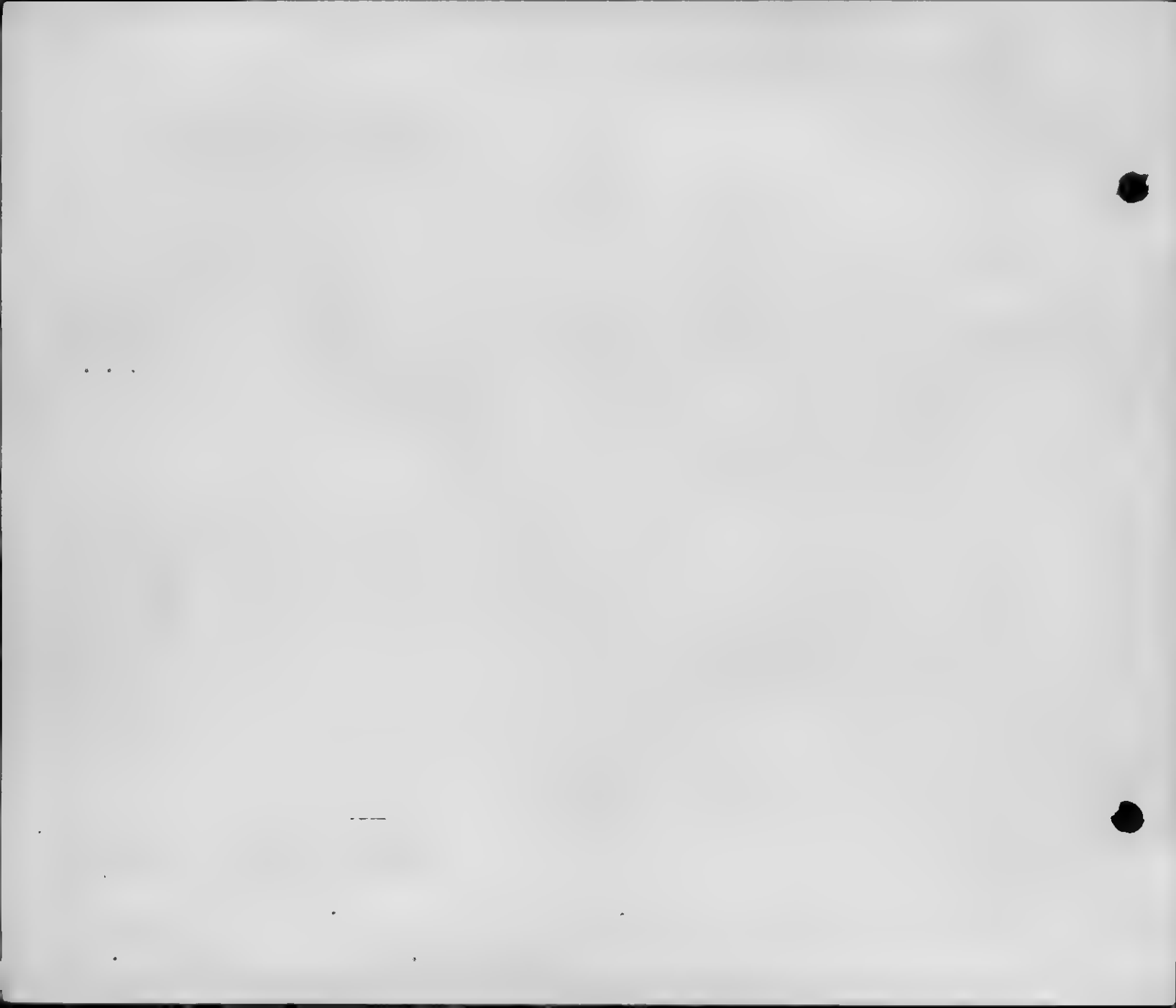
Re: 11548
 No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Baltimore</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Turners Station</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Turners Station</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>117 Oak Avenue</u>				STREET ADDRESS (If rural, give location) <u>117 Oak Avenue</u>			
3. NAME OF DECEASED: (First) <u>Dorman</u> (Middle) <u>Duval</u> (Last) <u>Cook</u>		4. DATE OF DEATH <u>12</u> <u>21</u> <u>19 55</u>		5. AGE last birthday: <u>6 weeks</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
6. SEX: <u>Male</u>	7. COLOR OR RACE: <u>Colored</u>	8. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	9. DATE OF BIRTH: <u>11/15/55</u>	10. BIRTHPLACE (State or foreign country): <u>Baltimore, Maryland</u>		11. CITIZEN OF WHAT COUNTRY: <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):				10b. KIND OF BUSINESS OR INDUSTRY:			
13. FATHER'S NAME: <u>Unknown</u>				14. MOTHER'S MAIDEN NAME: <u>Mattie Cook</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>Alec Cook 117 Oak Avenue</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
Immediate cause (a) <u>Interstitial Pneumonitis</u> DUE TO							
Antecedent cause(s) (b) <u>DUE TO</u> Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Frank M. ...</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>12/21/55</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM.			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>12/22/55</u>		NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn</u>		LOCATION (City, town, or county) (State) <u>Mt. Winans, Maryland</u>	
DATE REC'D BY LOCAL REG. <u>12-22-55</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>Charles R. Law</u>		ADDRESS <u>802-04 Madison Ave.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A - 5 - 53



11593

CERTIFICATE OF DEATH

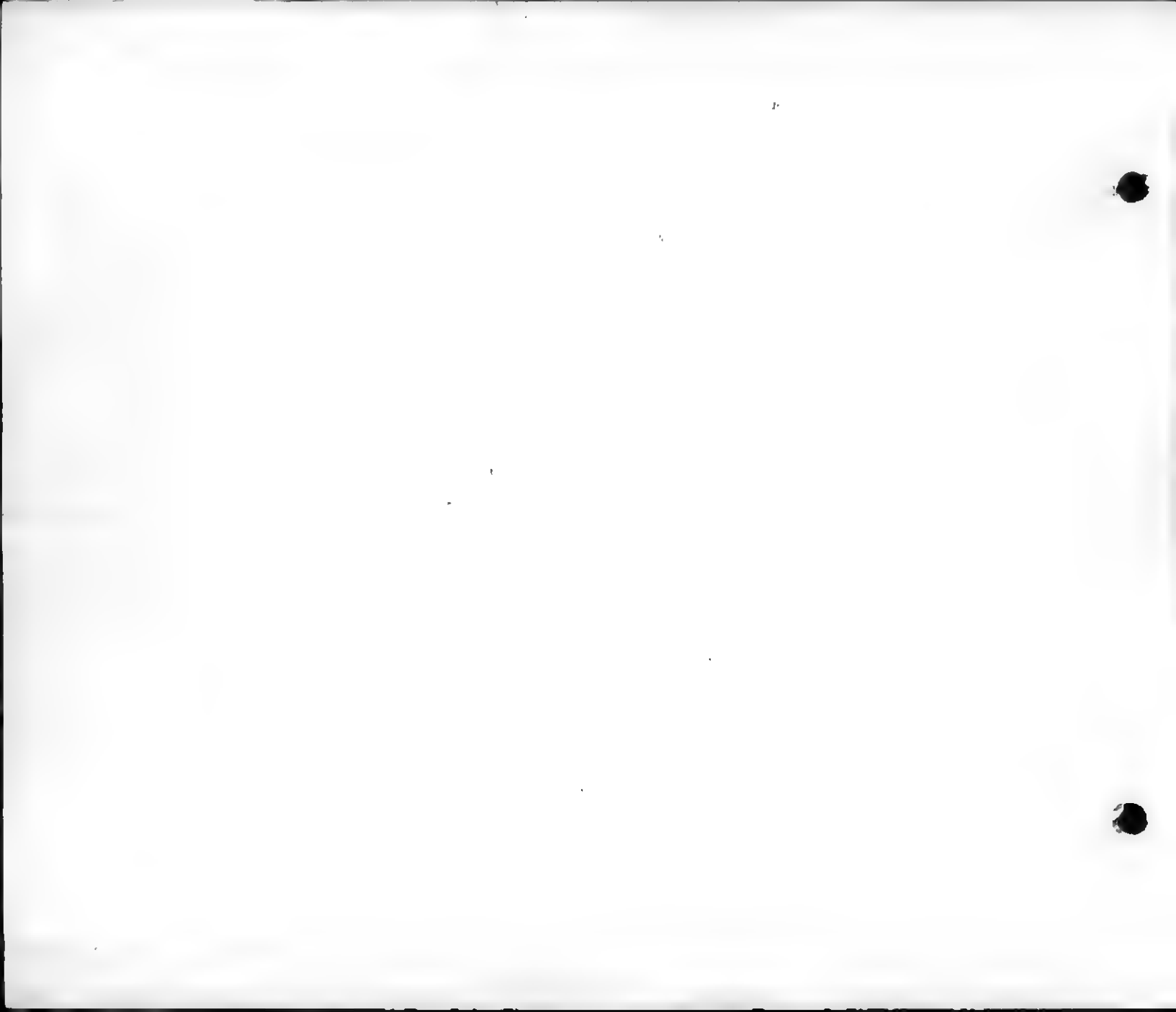
Reg. Dist. No.

11586

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Baltimore</i>	MARYLAND	STATE <i>Maryland</i>	COUNTY <i>Baltimore</i>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
<i>Rural, Stevenson</i>	<i>7 yrs.</i>	<i>Rural, Stevenson</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS	
<i>Stevenson Rd, extended</i>		<i>Stevenson Rd, extended</i>	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <i>ora Belle</i>	(Middle) <i>cook</i>	(Month) <i>Dec 17</i>	(Day) <i>1955</i>
(Type or Print)		(Year)	
5. SEX: <i>Female</i>	6. COLOR OR RACE: <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): <i>single</i>	8. DATE OF BIRTH: <i>18 Jan 1894</i>
		9. AGE last birthday: <i>61</i> yrs	IF UNDER 1 YEAR: Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>none</i>		10B. KIND OF BUSINESS OR INDUSTRY: <i>none</i>	11. BIRTHPLACE (State or foreign country): <i>Georgia</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME: <i>Lewis Cook</i>		14. MOTHER'S MARDEN NAME: <i>Sarah Calhwell</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk) (If Yes, give war or dates of service): <i>no</i>		16. SOCIAL SECURITY NO.: <i>none</i>	
17. INFORMANT & ADDRESS: <i>Mrs KC Truitt, Stevenson P.O. Ind,</i>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <i>450.0 generalized arteriosclerosis</i>			<i>6 yrs</i>
ANTECEDENT CAUSE (B) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <i>none</i>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>27 Mar, 1953</i> to <i>17 Dec, 1953</i> that I last saw the deceased alive on <i>17 Dec, 1955</i> , and that death occurred at <i>3:15 P.M.</i> from the causes and on the date stated above.			
SIGNATURE <i>Paul H. Rouse</i>		DATE SIGNED <i>17 Dec 55</i>	
ADDRESS <i>Pikesville 8 Ind</i>		M. D. <i>Pikesville 8 Ind</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Removal</i>		DATE THEREOF <i>12/20/55</i>	
NAME OF CEMETERY OR CREMATORY <i>Hillside Cem.</i>		LOCATION (City, town, or county) (State) <i>Rutherford, N. J.</i>	
DATE REC'D BY LOCAL REGISTRAR <i>12-19-55</i>		REGISTRAR'S SIGNATURE <i>H. W. Bedrock</i>	
24. FUNERAL DIRECTOR <i>Thos. Pickens & Sons - Balt</i>		ADDRESS <i>17 Md</i>	

MARGIN RESERVED FOR PRINTING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



11594

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Baltimore</i>		STATE <i>Maryland</i>		COUNTY <i>Baltimore</i>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <i>Jefferson Rural</i>		<i>Life</i>		TOWN <i>Jefferson, Rural</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Trenton</i>				STREET ADDRESS (If rural give location) <i>Trenton</i>			
3. NAME OF DECEASED (Type or Print) <i>Laura Belle Croft</i>				4. DATE OF DEATH (Month) (Day) (Year) <i>Dec. 29 1955</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Widow</i>		8. DATE OF BIRTH <i>June 1, 1868</i>	
9. AGE last birthday <i>87</i> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Noah Thompson</i>		14. MOTHER'S MAIDEN NAME <i>Rachel Brown</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or up to) <i>No</i> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT & ADDRESS <i>Mrs. Margaret Myers, Jefferson Rd</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <i>Chronic Myocarditis</i>				INTERVAL BETWEEN ONSET AND DEATH <i>—</i>			
ANTECEDENT CAUSE(S) DUE TO (B) <i>Arteriosclerotic Coroner-Vascular Disease</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <i>—</i>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH <i>—</i>							
19a. DATE OF OPERATION <i>—</i>		19b. MAJOR FINDINGS OF OPERATION <i>—</i>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <i>—</i>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <i>—</i>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <i>—</i>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <i>—</i>			
22. I hereby certify that I attended the deceased from <i>July 1, 1947</i> , to <i>Dec 29, 1955</i> , that I last saw the deceased alive on <i>Dec 13, 1955</i> , and that death occurred at <i>1:45 P.M.</i> , from the causes and on the date stated above.							
SIGNATURE <i>Joseph B. B...</i>				ADDRESS (Street, city, town, state) <i>Hampstead Md</i>		DATE SIGNED <i>12-29-55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>12-31-55</i>		NAME OF CEMETERY OR CREMATORY <i>Trenton</i>		LOCATION (City, town, or county) (State) <i>Balta Co Md</i>	
24. REC'D BY REGISTRAR <i>—</i>		REGISTRAR'S SIGNATURE <i>Mary B. Eline</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>—</i>		ADDRESS <i>—</i>	
DATE <i>12-31-55</i>							

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

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RECEIVED

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11589

11595 CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Catonsville</u>				TOWN <u>Severna Pk.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>House in Pines Nursing Home</u> <u>16 Fusting Avenue</u>				STREET ADDRESS (If rural give location) <u>Riggs Ave.</u>			
3. NAME OF DECEASED (Type or Print) <u>KATHERINE W. COX</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Dec 20 1955</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>Nov. 23, 1857</u>	9. AGE last birthday <u>98</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Ireland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William J. Wright</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>---</u>		16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT & ADDRESS <u>Miss Ellen L. Cromwell, 1419 John Street</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>After an acute heart attack</u>						<u>6 yrs</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3 AM</u> , 19 <u>55</u> , to <u>PM</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Dec 19</u> , 19 <u>55</u> , and that death occurred at <u>3 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Francis J. Cook</u> M.D.				DATE SIGNED <u>Box 388 Severna Park Md 12/20/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>burial</u>		DATE THEREOF <u>12/23/55</u>		NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>		LOCATION (City, town, or county) (State) <u>Annapolis, Maryland</u>	
24. REC'D BY REGISTRAR <u>DEC 23 1955</u>		REGISTRAR'S SIGNATURE <u>T. E. Harry</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm Cook Inc</u> ADDRESS <u>1217 St. Paul St.</u>			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

DEC 21

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been examined by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be attached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11596

CERTIFICATE OF DEATH

11590

Reg. Dist. No. 38

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Baltimore</u>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>Rural-Freeland</u>	<u>35 yrs.</u>	TOWN <u>Rural-Freeland</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
<u>Keeny Mill Rd.</u>		<u>Keeny Mill Rd.</u>	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) (Middle) (Last)		(Month) (Day) (Year)	
<u>Emma Retta Craig</u>		<u>Dec. 13, 1955</u>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
<u>Female</u>	<u>White</u>	<u>Widow</u>	<u>June 29/1866</u>
9. AGE last birthday	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
<u>89 yrs.</u>	<u>Housewife</u>	<u>Equinox N.Y.</u>	<u>U.S.A.</u>
13. FATHER'S NAME	14. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.)	15. SOCIAL SECURITY NO.	16. MOTHER'S MAIDEN NAME
<u>Obediah Palmer</u>	<u>No</u>		<u>Angeline Armstrong</u>
17. INFORMANT'S ADDRESS		18. MEDICAL CERTIFICATION	
<u>Mrs. Helen Leithiser, Freeland, Md.</u>		I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	
		19. IMMEDIATE CAUSE (A)	
		<u>ARTERIO SCLEROSIS</u>	
		20. ANTECEDENT CAUSE(S) DUE TO	
		<u>SENILE Psychosis</u>	
		21. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	
		22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
<input type="checkbox"/>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?		21g. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
22. I hereby certify that I attended the deceased from <u>10-19</u>, 19<u>55</u>, to <u>12/12</u>, 19<u>55</u>, that I last saw the deceased alive on <u>12/12</u>, 19<u>55</u>, and that death occurred at <u>3:30</u> M., from the causes and on the date stated above.			
SIGNATURE		ADDRESS (Street, city, town, state)	
<u>Jacobs Schatanoff</u>		<u>New Freedom Pa.</u>	
DATE		DATE SIGNED	
<u>12/14/55</u>		<u>12/14/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		24. NAME OF CEMETERY OR CREMATORY	
<u>Burial</u>		<u>Prospect Hill Cemetery</u>	
DATE THEREOF		LOCATION (City, town, or county) (State)	
<u>Dec. 15/1955</u>		<u>York, Pa.</u>	
24. REC'D BY REGISTRAR		25. FUNERAL DIRECTOR'S SIGNATURE	
REGISTRAR'S SIGNATURE		ADDRESS	
<u>Charles J. Pugh</u>		<u>Jacobs Hartenstein, New Freedom, Pa.</u>	



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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11597 CERTIFICATE OF DEATH

11591

Reg. Dist. No. 38

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		STATE <u>Maryland</u>		COUNTY			
CITY (If outside corporate limits, write RURAL OR end give nearest town) <u>Parkville</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Oak Haven Nursing Home 9008 Harford Road</u>				STREET ADDRESS (If rural give location) <u>2402 E. Federal Street</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Mr. Denton Allan Cullison</u>				<u>December 24 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>male</u>	<u>white</u>	<u>widowed</u>	<u>Sept. 18, 1880</u>	<u>75</u> yrs.	Months Days	Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-09-5817</u>		17. INFORMANT & ADDRESS <u>Mr. Gordon W. Cullison 5011 Oaklyn Ave #6</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<u>151X IMMEDIATE CAUSE (A) <u>Carcinoma, stomach</u></u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Arteriosclerosis, generalized</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept. 16, 1955</u>, to <u>Dec. 24, 1955</u>, that I last saw the deceased alive on <u>Dec. 27, 1955</u>, and that death occurred at <u>4:10</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Charles J. Lucif</u>		M.D. <u>5101 Belair Rd</u>		ADDRESS (Street, city, town, state)		DATE SIGNED <u>12/24/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Dec. 27, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Baltimore Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Dr. R. M. Bacon</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		ADDRESS <u>5305 Harford Road #14</u>	
DATE							

PUERTO V. S.

DEC 20 1959

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

11592

11598

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 35

1. PLACE OF DEATH: COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>MARYLAND</u> COUNTY <u>Calverton</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>GIEN ARM</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Notch Cliff Rd</u>		STREET ADDRESS (If rural, give location) <u>2517 HERMOSA AVE</u>	
3. NAME OF DECEASED (First) <u>FELIX</u> (Middle) <u>J</u> (Last) <u>CURLS</u>		4. DATE OF DEATH (Month) <u>DEC</u> (Day) <u>7</u> (Year) <u>1955</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>Sept 22, 1922</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SEAMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OIL TANKER</u>	9. AGE last birthday <u>33</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>GEORGIA</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>JOHN M. CURLS</u>		14. MOTHER'S MAIDEN NAME <u>CLARA L. Mc DONALD</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>215-12-5586</u>	
17. INFORMANT AND ADDRESS <u>JOHN CURLS 2517 HERMOSA AVE</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
47. 1 Immediate cause (a) <u>Cochran Monoxide Poison</u>		<u>Sudden</u>
Antecedent cause(s) (b) <u>(Auto Exhaust Funnelled into Car with Windows closed.)</u>		
(c) <u></u>		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing in the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

DEC 14 1955

RECEIVED

11599

CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Ret</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Colgate</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Colgate</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>7526 Carson Ave.</u>				STREET ADDRESS (If rural give location) <u>7526 Carson Ave.</u>			
3. NAME OF DECEASED: (First) <u>GEORGE</u> (Middle) <u>A.</u> (Last) <u>CURTIS</u>				4. DATE OF DEATH: <u>Dec. 15, 1955</u> 19			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>Nov. 29, 1876</u>	9. AGE last birthday: <u>79</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Maine</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Richard Curtis</u>				14. MOTHER'S MAIDEN NAME: <u>?</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>No.</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>Mrs. Eleanor M. 7526 Carson Ave.</u>			

18. MEDICAL CERTIFICATION		Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
<u>420.1</u> Immediate cause (a) <u>Coronary Occlusion</u> DUE TO		<u>Sudden</u>
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <u>Arteriosclerotic Cardio-Vascular disease</u> DUE TO		<u>2 yrs</u>
(c)		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) <u>HOMICIDE</u>	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 1, 1955, to Dec 15, 1955, that I last saw the deceased alive on Dec 15, 1955, and that death occurred at 9 A.M., from the causes and on the date stated above.

SIGNATURE <u>M. D. Bannum</u> (Degree or title)		ADDRESS <u>Baltimore Md</u>		DATE SIGNED <u>12/15/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)		
<u>Burial</u>	<u>Dec. 17, 1955</u>	<u>Parkwood</u>	<u>Parkville, Md.</u>		
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR		ADDRESS	
<u>Dec 17-1955</u>	<u>William M. Kelly</u>	<u>Ullrich Funeral Home</u>		<u>2112 Dundalk Ave.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
U. S. BUREAU

RECEIVED
U. S. BUREAU

11600

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11504 Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 2

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Balt.</i>	MARYLAND	STATE <i>Md.</i>	COUNTY <i>Baltimore</i>
CITY (If outside corporate limits, write RURAL OR and give nearest town), TOWN <i>mt. Wilson</i>		CITY (If outside corporate limits write RURAL and give nearest town) TOWN <i>Balt. 18</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>mt. Wilson Hosp.</i>		STREET ADDRESS (If rural, give location) <i>1214 E. Cold Spring Lane</i>	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) <i>KATHERINE</i>	(Middle) <i>MARIS</i>	(Last) <i>D'ANNA</i>	(Month) <i>Dec</i> (Day) <i>19</i> (Year) <i>55</i>
5. SEX: <i>Female</i>	6. COLOR OR RACE: <i>W.</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): <i>WIDOWED</i>	8. DATE OF BIRTH: <i>3-11-12</i>
9. AGE last birthday: <i>43</i> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <i>housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY: <i>housewife</i>	
11. BIRTHPLACE (State or foreign country): <i>Balt.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <i>Samuel Cammarata</i>		14. MOTHER'S MAIDEN NAME: <i>Stella Cammarata</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <i>215 7-1-48</i>		16. SOCIAL SECURITY No.: <i>none</i>	
17. INFORMANT & ADDRESS: <i>T. T. Wilson</i>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <i>Fractured L. ankle, knee, elbow spine & ribs.</i>			<i>Instant.</i>
Antecedent cause(s) (b) <i>Dropped from 7th fl. roof.</i>			
Diseases or conditions, if any, giving rise to the above cause (c) <i>stating underlying cause last</i>			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Pulmonary etc. Since 1948</i>			
19a. DATE OF OPERATION: <i>Apr 156</i>		19b. MAJOR FINDING OF OPERATION: <i>Pulmonary etc.</i>	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <i>mt. Wilson Hosp.</i>	
21c. (City or town) (County) (State) <i>Balt. Md.</i>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <i>Apr 7 55 4 M.</i>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
21f. HOW DID INJURY OCCUR? <i>Auto. jumped from 7th fl. roof.</i>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <i>A.D. Taylor</i>		M. D. <i>12-4-55</i>	
23. BURIAL, CREMATION, REMOVAL (Specify): <i>Burial</i>		DATE THEREOF: <i>12/13/55</i>	
NAME OF CEMETERY OR CREMATORY: <i>New Cathedral Cem.</i>		LOCATION (City, town, or county) (State): <i>Balto., Md.</i>	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE: <i>12-13-55</i>		24. FUNERAL DIRECTOR: <i>Wm. J. Dickner & Sons - Balto 17</i>	
ADDRESS: <i>md</i>			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



11601

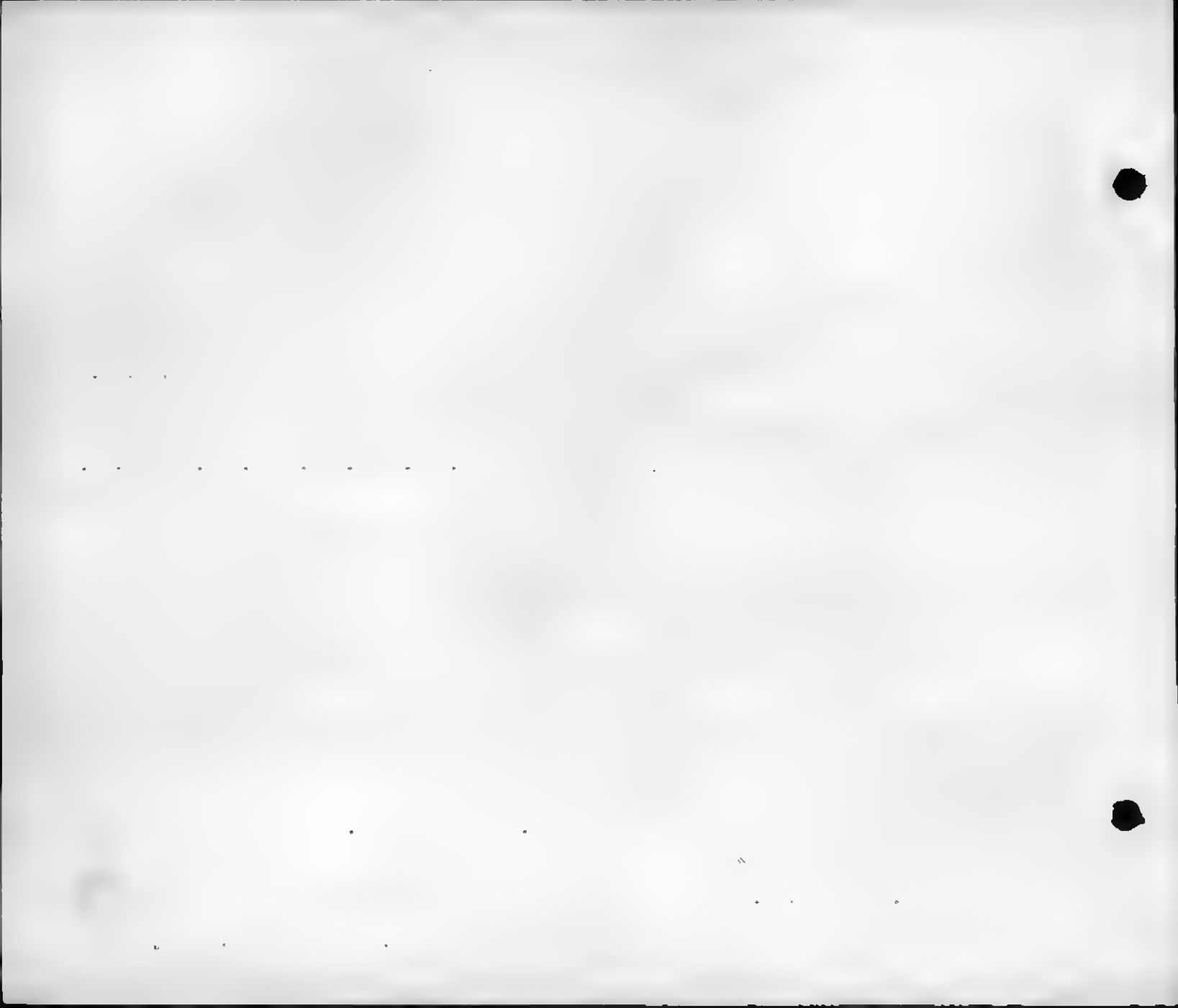
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED.			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>			
X TOWN <u>Fort Howard</u>		<u>29 Days</u>		STREET ADDRESS (If rural give location)			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>				<u>1017 Rutland Avenue</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>ADOLPH DAVIS</u>				OF DEATH: <u>December 27 1955</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>Colored</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>January 28, 1896</u>	
9. AGE last birthday: <u>59</u> yrs.		10. BIRTHPLACE (State or foreign country): <u>Thomasville, Alabama</u>		11. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Laborer</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>Steel Mill</u>			
13. FATHER'S NAME: <u>Eugene Davis</u>				14. MOTHER'S MAIDEN NAME: <u>Viola Burson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>Yes</u> (If Yes, give war or dates of service): <u>WW I</u>				16. SOCIAL SECURITY NO. <u>213-09-1350</u>			
17. INFORMANT & ADDRESS: <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>							
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>BRONCHOGENIC CARCINOMA OF RIGHT UPPER LOBE WITH METASTASIS TO MEDIASTINAL LYMPH NODES AND BLADDER</u>							
ANTECEDENT CAUSE (B) <u>LYMPH NODES AND BLADDER</u>						6 MONTHS	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>12/30/55</u>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22 I hereby certify that I attended the deceased from Nov. 28, 1955, to Dec. 27, 1955, that I last saw the deceased on <u>Dec. 27, 1955</u> and that death occurred at <u>7:25 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Donald D. Mark, M.D.</u>		ADDRESS <u>M.D. VAH, FORT HOWARD, MARYLAND</u>		DATE SIGNED <u>12-27-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12/30/55</u>		NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cem.</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>12-28-55</u>		REGISTRAR'S SIGNATURE <u>Chas. H. Hestrich</u>		24. FUNERAL DIRECTOR <u>Joseph G. Locks, Jr.</u>		ADDRESS <u>Baltimore, Maryland</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

11596

11602 CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 30

1. PLACE OF DEATH- COUNTY Baltimore		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Prince George's County	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Baltimore		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Cheverly	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Spring Grove Hospital		STREET ADDRESS (If rural, give location) 2814- 63rd Ave.	
3. NAME OF DECEASED (Type or Print) (First) John (Middle) Wesley (Last) Dean		4. DATE OF DEATH (Month) Dec. (Day) 1 (Year) 1955	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Widowed	8. DATE OF BIRTH 6/14/1869
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday 86 yrs.
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert Dean		14. MOTHER'S MAIDEN NAME Jenkins	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS Spring Grove Hospital Records, Catonsville.			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) Acute Cardiac Failure Antecedent cause(s) (b) Hypertensive cardiovascular disease with dehydration. Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) Fracture of right hip.		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Mental illness		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE) Catonsville Baltimore Maryland
TIME (Month) (Day) (Year) (Hour) OF INJURY Sept. 10, 1955 m.	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? Patient fell out of bed

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE <i>Dr. M. Kieffer, Jr.</i>		ADDRESS 1010 Leeds Avenue		DATE SIGNED Dec. 1, 1955
DATE OF DEATH Dec. 5-1955	NAME OF CEMETERY OR CREMATORY Cedar Hill	LOCATION (City, town, or county) Seigfield Md.	(State)	
DATE REC'D BY LOCAL REG. 12-1-55	REGISTRAR'S SIGNATURE <i>T.E. Harry</i>	24. FUNERAL DIRECTOR <i>J. Williams</i>	ADDRESS <i>Irish D.C.</i>	

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MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

11597

Reg. Dist. No. 38

11603

1. PLACE OF DEATH- COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MARYLAND</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>PARKVILLE</u> LENGTH OF STAY (in this place) <u>33 years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>PARKVILLE</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>8304 HARFORD RD</u>		STREET ADDRESS (If rural, give location) <u>8304 HARFORD RD</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>James</u>	(Middle)	(Last) <u>DeOMS SA</u>
4. DATE OF DEATH	(Month) <u>Dec</u>	(Day) <u>27</u>	(Year) <u>1951</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>JUNE 26 - 1887</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PAPER HANGER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self-Emp.</u>	9. AGE last birthday <u>68</u> yrs. If under 1 year Months Days If under 24 hrs Hours Min.
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Charles Deoms</u>		14. MOTHER'S MAIDEN NAME <u>MARY VENCOUR</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>216-05-8283</u>	
17. INFORMANT AND ADDRESS <u>LAURA DeOMS 8304 HARFORD RD</u>			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Coronary Occlusion</u>			<u>Sudden</u>
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/>			
SIGNATURE <u>Charles F. O'Donnell M.D.</u>		ADDRESS <u>7501 York Rd. Towson</u> DATE SIGNED <u>12/27/55</u>	
23. BURIAL, CREMATION OR DISPOSAL (Specify) <u>BURIAL</u>		DATE THEREOF <u>12-31-55</u> NAME OF CEMETERY OR CREMATORY <u>BALTIMORE</u> LOCATION (City, town, or county) <u>BALTIMORE</u> (State) <u>MD</u>	
DATE REC'D BY LOCAL REG. <u>12/27/55</u>		REGISTRAR'S SIGNATURE <u>G. H. Bacon</u> 24. FUNERAL DIRECTOR <u>CHAS. F. EVANS & SON</u> ADDRESS <u>8804 HARFORD RD</u>	

MARGIN RESERVED FOR BINING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS MMC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11598

11604

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>BALTIMORE</u> MARYLAND CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>220 BRANDON RD.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u> COUNTY <u>DALTO.</u> CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u> STREET ADDRESS (If rural give location) <u>220 BRANDON RD.</u>	
3. NAME OF DECEASED (Type or Print) <u>JOSEPHINE ESTELLA DICK</u> (First) (Middle) (Last)		4. DATE OF DEATH (Month) (Day) (Year) <u>12-3-1955</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED <u>WIDOWED</u>	8. DATE OF BIRTH <u>JULY 20, 1878</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>	9. AGE last birthday <u>77</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>DALTO. MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>JOSEPH P. SLEE</u>		14. MOTHER'S MAIDEN NAME <u>SARAH C. EDWARDS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>215-03-9877</u>	
17. INFORMANT & ADDRESS <u>MRS. MARY COOK-220 BRANDON RD.</u>			
18. MEDICAL CERTIFICATION DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u> ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic Cardio Vascular Disease & Hypertension</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Disease & Hypertension</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>1 year</u>
19. DATE OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) (Second)	
21e. INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Jan 2-9</u> , 19 <u>51</u> , to <u>3-Dec</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>3-Dec</u> , 19 <u>55</u> , and that death occurred at <u>11 P.M.</u> from the causes and on the date stated above. SIGNATURE <u>Charles W. Jenkins, M.D.</u> ADDRESS (Street, city, town, state) <u>2746 The Alameda BALTO. MD.</u> DATE SIGNED <u>3-Dec-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>	DATE THEREOF <u>12/5/55</u>	NAME OF CEMETERY OR CREMATORY <u>WESTERN CEM.</u>	LOCATION (City, town, or county) (State) <u>DALTO. MD.</u>
24. REC'D BY REGISTRAR <u>DEC 5 1955</u>	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE <u>H.W. JENKINS & Sons Co. 4905 YORK RD.</u>	

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 155 10A

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11605

CERTIFICATE OF DEATH

11599

Reg. Dist. No. 28

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		STATE <u>Maryland</u> COUNTY		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		TOWN <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		LENGTH OF STAY (In this place) <u>10 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sorenson Nursing Home</u>		STREET ADDRESS (If rural give location) <u>601 Parkwyth Avenue #18</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		TOWN <u>Baltimore</u>	
3. NAME OF DECEASED (Type or Print) <u>Mrs. Alice S. Dougherty(Daugherty)</u>				4. DATE OF DEATH (Month) <u>Dec.</u> (Day) <u>27th</u> (Year) <u>19 55</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>		8. DATE OF BIRTH <u>July 22, 1872</u>	
9. AGE last birthday <u>83</u> yrs.		10. IF UNDER 1 YEAR (Month) <u>5</u> (Day) <u>5</u>		11. IF UNDER 24 HRS. (Hours) <u>5</u> (Min.) <u>5</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Mr. George W. Dougherty</u>				14. MOTHER'S MAIDEN NAME <u>Mary J. Woods</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mrs. Helen Haymes, 4211 Harcourt Road #11</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
IMMEDIATE CAUSE (A) <u>Myocarditis chronic with failure</u>				ANTECEDENT CAUSE(S) DUE TO (B) <u>Myocardial hypertrouhy</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>Advancing years</u>				III. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Advancing years</u>			
19a. DATE OF OPERATION <u>no operation</u>		19b. MAJOR FINDINGS OF OPERATION <u>no operation</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. PLACE (Home, farm, factory, etc.) OF INJURY <u>no injury</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>no injury</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>no injury</u>			
22. I hereby certify that I attended the deceased from <u>Dec. 17, 1955</u>, to <u>Dec. 27, 1955</u>, that I last saw the deceased alive on <u>Dec. 25, 1955</u>, and that death occurred at <u>6:30 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>James Graham Manton, M.D.</u>				ADDRESS (Street, city, town, state) <u>510 Cathedral Street</u>			
DATE SIGNED <u>Dec. 29, 1955</u>				DATE SIGNED <u>Dec. 27, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Dec. 29, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery</u>		LOCATION (City, town, or county) <u>Baltimore, Maryland</u>	
24. REC'D BY REGISTRAR <u>Mabel Gray</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Duck</u>		ADDRESS <u>5305 Harford Road #11</u>	

BURMAN V. S.

DEC 23 1935

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TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

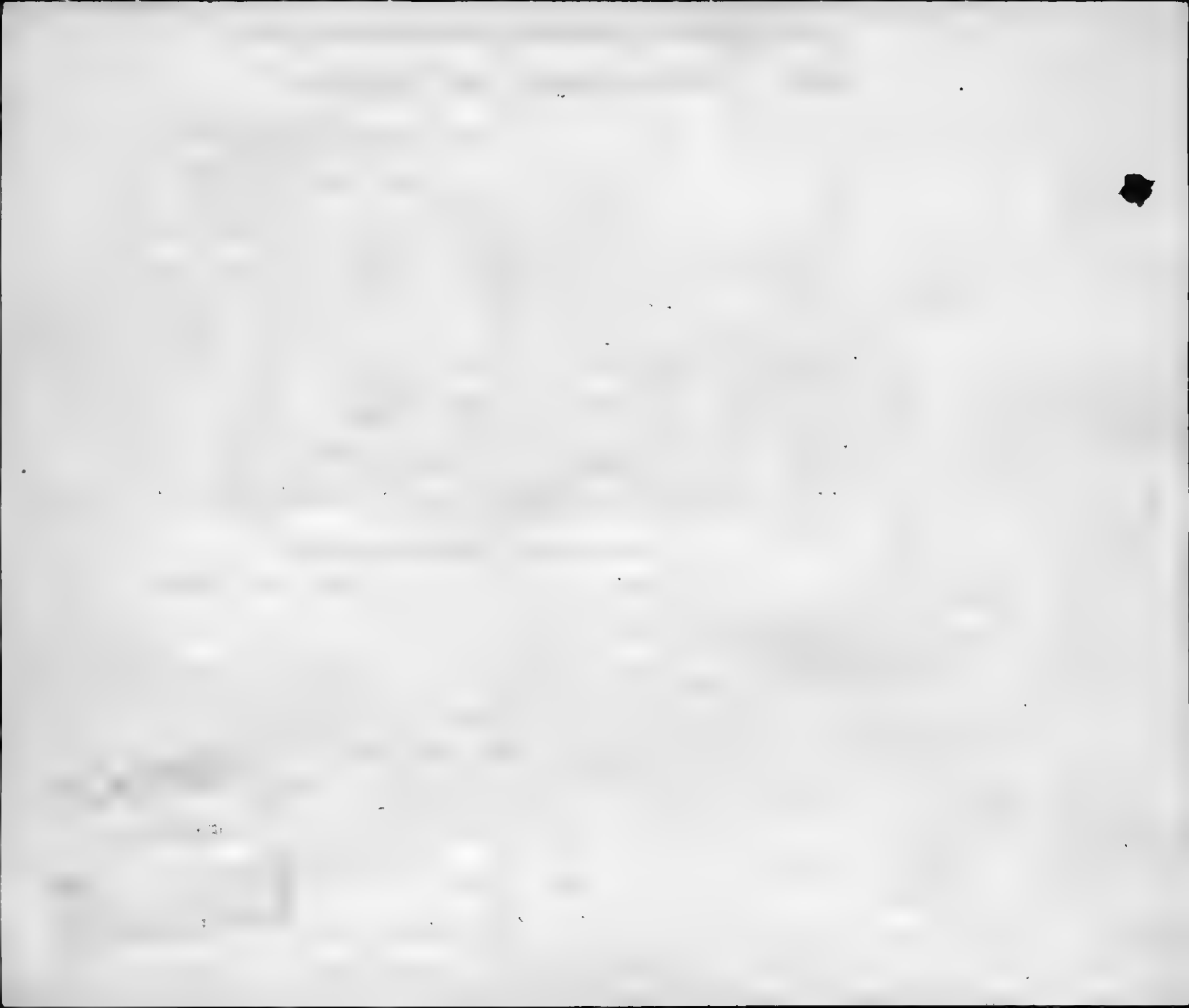
VS AISC 1-55 104

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11550 **CERTIFICATE OF DEATH**11600
42

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		STATE <u>Maryland</u> COUNTY <u>Baltimore</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>Arbutus</u>		LENGTH OF STAY (in this place)		TOWN <u>Arbutus</u>		TOWN <u>Arbutus</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2215 Sulphur Spring Road</u>				STREET ADDRESS (If rural give location) <u>2215 Sulphur Spring Road</u>			
3. NAME OF DECEASED (First) <u>JOHN</u> (Middle) <u>M.</u> (Last) <u>EAKMAN</u>				4. DATE OF DEATH (Month) <u>Dec.</u> (Day) <u>16,</u> (Year) <u>1955</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>		8. DATE OF BIRTH <u>Oct. 29, 1884</u>	
9. AGE last birthday <u>71</u> yrs.		IF UNDER 1 YEAR (Months) <u>16,</u> (Days) <u>19</u>		IF UNDER 24 HRS. (Hours) <u>55</u> (Min.)			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Store Keeper Gauger - Int. Rev.</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John M. Eakman</u>				14. MOTHER'S MAIDEN NAME <u>Hattie E. Davis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service) <u>--</u>				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mary E. Eakman, 2215 Sulphur Sp. Rd.</u>	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Myocardial Infarction</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertensive Cardiovascular Disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>arteriosclerotic</u>						5 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <u>7-29</u> , 19 <u>50</u> , to <u>12-16</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12-16</u> , 19 <u>55</u> , and that death occurred at <u>12:20 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>John P. Unlook, Jr.</u>				ADDRESS (Street, city, town, state) <u>1227 Waverly Blvd Baltimore</u>			
DATE <u>12-17-55</u>				DATE SIGNED <u>12-17-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12/19/55</u>		NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Wm. Cook, Jr.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook, Jr.</u>		ADDRESS <u>1217 St. Paul Street</u>	



11606

CERTIFICATE OF DEATH

Reg. Dist. No. 35

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>BALTIMORE</u>	MARYLAND	STATE <u>MARYLAND</u>	COUNTY <u>Balto.</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>PARKTON P.O.</u>		TOWN <u>Parkton P.O.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>PARSONAGE Rd., Rayville</u>		STREET ADDRESS (If rural give location) <u>Parsonage Rd., Rayville</u>	
3. NAME OF DECEASED: (First) <u>John</u> (Middle) <u>Charles</u> (Last) <u>Enders</u>		4. DATE OF DEATH: (Month) <u>Dec</u> (Day) <u>15</u> (Year) <u>1955</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>Dec. 12, 1878</u>
9. AGE last birthday: <u>77</u> yrs.		10. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
11. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <u>Watchman</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Henry Enders</u>		14. MOTHER'S MAIDEN NAME: <u>Elizabeth Bense</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY No.: <u>None</u>	
17. INFORMANT & ADDRESS: <u>Family Records</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	Interval Between Onset And Death
Immediate cause (a) <u>Cerebral thrombosis</u>	<u>4 days</u>
Antecedent causes (s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.	
(c)	

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY?	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)
SUICIDE	(CITY OR TOWN) (COUNTY) (STATE)
HOMICIDE	
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While at Work <input type="checkbox"/>
HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 12/14/55, 19... to 12/15/55, 19... that I last saw the deceased alive on 12/14/55, 19... and that death occurred at 2:30 PM, from the causes and on the date stated above.

SIGNATURE <u>C. M. Frame</u>	DATE SIGNED <u>12/15/55</u>
23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF
<u>Burial</u>	<u>Dec. 17, 1955</u>
NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>St. John's Lutheran Cem.</u>	<u>Sweet Air, Balto. Co., Md.</u>
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE
<u>12-20-55</u>	<u>Mrs. Howard S. Mathews</u>
24. FUNERAL DIRECTOR	ADDRESS
<u>John Burns' Sons, Foreman, Ind.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
DEC 2 1944
BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11602

11607

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Balto.</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Catonsville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>6628 Altamont Ave.</u>				STREET ADDRESS (If rural give location) <u>6628 Altamont Ave.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>EMMETT W. ENTRIKEN</u>				<u>Dec. 20, 19 55</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.	
<u>male</u>	<u>white</u>	<u>married</u>	<u>July 15, 1886</u>	<u>69</u> yrs.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
<u>physico therapist -self emp</u>				<u>-self emp</u>		<u>Kansas</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Samuel C. Entriken</u>				<u>Emma Waggoner</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
<u>yes</u> <u>World War</u>				<u>No I--</u>		<u>Mrs. Ethel Entriken-6628 Altamont Ave.</u>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
(A) IMMEDIATE CAUSE						<u>5 min.</u>	
(B) ANTECEDENT CAUSE (S):						<u>2 yr.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)			
				21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
				21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1/3</u> 19 <u>54</u> , to <u>12/20</u> , 19 <u>55</u> that I last saw the deceased alive on <u>10/21</u> 19 <u>55</u> , and that death occurred at <u>9³⁰ AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Robert A. Reiter</u>				ADDRESS <u>3408 Windsor Ave.</u>			
DATE SIGNED <u>12/22/55</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)				DATE THEREOF			
<u>Burial</u>				<u>12/23/55</u>			
NAME OF CEMETERY OR CREMATORY				LOCATION (City, town, or county) (State)			
<u>Baltimore National Cem.</u>				<u>Catonsville, Md.</u>			
DATE REC'D BY LOCAL REGISTRAR				24. FUNERAL DIRECTOR ADDRESS			
<u>12-23-55</u>				<u>Wm. J. Vickers & Sons - Balt. Md.</u>			



11608 CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Catonsville</u>		<u>5 yrs</u>		TOWN <u>Catonsville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1124 Ingleside Ave.</u>				STREET ADDRESS (If rural give location) <u>5929 Queen Anne St</u>			
3. NAME OF DECEASED (Type or Print) <u>Anna Fleck</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Dec. 21/55</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>June 24, 1884</u>	
				9. AGE last birthday <u>71</u> yrs.		10. IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Braun</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Son</u>	
				<u>Carl Fleck 5929 Queen Anne St</u>			
18. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						19. INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>						<u>1 day</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertensive Cardio-Vascular Disease</u>						<u>10 yrs.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Diabetic Mellitus</u>						<u>10 yrs.</u>	
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11-8</u> , 19 <u>57</u> , to <u>12-21</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12-13</u> , 19 <u>55</u> , and that death occurred at <u>8 P.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Thomas H. Gallagher</u>				ADDRESS (Street, city, town, state) <u>M.D. 6204 Frederick Ave Balt. 28</u>			
				DATE SIGNED <u>12/22/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Dec. 24/55</u>		NAME OF CEMETERY OR CREMATORY <u>Loudon Pk.</u>		LOCATION (City, town, or county) (State) <u>Baltimore 29 Md.</u>	
24. REC'D BY REGISTRAR <u>DEC 21 1955</u>		REGISTRAR'S SIGNATURE <u>J. E. Hays</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Harvey H. Wingle</u>		ADDRESS <u>4207 Edmondson Ave</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

RECEIVED

DEC 21 1954

RECEIVED

11604

11609

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No.

1. PLACE OF DEATH- COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Md. COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL and give nearest town) Middle River		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) Middle River	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Box 524 RT 16				STREET ADDRESS (If rural, give location) Box 524 RT 16	
3. NAME OF DECEASED (Type or Print) Robert (First) Stewart (Middle) Fleckenstine (Last)		4. DATE OF DEATH Dec 12 1955		5. AGE last birthday 36 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.	
6. SEX Male	7. COLOR OR RACE White	8. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	9. DATE OF BIRTH Dec 20, 1918	10. AGE last birthday 36 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		11b. KIND OF BUSINESS OR INDUSTRY Rheems		11. BIRTHPLACE (State or foreign country) York Pa.	
12. FATHER'S NAME Karl S. Fleckenstine		13. MOTHER'S MAIDEN NAME Marie Baum		14. CITIZEN OF WHAT COUNTRY? U. S. A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (Yes) (If yes, give war or dates of)		16. SOCIAL SECURITY No.		17. INFORMANT AND ADDRESS Parents Same	
18. MEDICAL CERTIFICATION					
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) Coronary Occlusion				5 min.	
Antecedent cause(s) (b) 1 1/2 years Chronic Cardiovascular renal disease				5 years	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .					
SIGNATURE Jack C. Collins, M.D.		DATE 12-15-55		DATE SIGNED Baltimore 22 12-15-55	
23. BURIAL, CREMATION (Specify) Removal		NAME OF CEMETERY OR CREMATION Fairview Cemetery		LOCATION (City, town, or county) (State) Wrightsville Pa.	
DATE REC'D BY LOCAL Dec 15, 1955		REGISTRAR'S SIGNATURE A. W. Hedrick		24. FUNERAL DIRECTOR John G. Connelly ADDRESS Essex Md.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Call

Murdock 6-7474

11600

CERTIFICATE OF DEATH

Reg. Dist. No. 37

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Pennsylvania</u>	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR	
TOWN <u>Timonium</u>		TOWN <u>Troutrum</u>	<u>75X-3</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>42 Greenmeadow Drive</u>		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<u>MARGERET ANN FOLGER</u>		OF DEATH: <u>Dec. 1, 1955</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widow</u>	8. DATE OF BIRTH: <u>Nov. 10, 1872</u>
9. AGE last birthday <u>83</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country): <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Patrick Kittell</u>		14. MOTHER'S MAIDEN NAME: <u>Cecelia Hart</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>No</u> (If Yes, give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT & ADDRESS: <u>Timonium, Md. Mrs. John Walker, 42 Greenmeadow Dr.</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(A) IMMEDIATE CAUSE <u>OCCCLUSION OF CORONARY ARTERY</u>		<u>3 days</u>	
(B) ANTECEDENT CAUSE (S) <u>ARTERIOSCLEROSIS</u>		<u>15 yrs</u>	
(C) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>SENILITY</u>		<u>15 yrs.</u>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>None</u>			
19A. DATE OF OPERATION: <u>None</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>None</u>		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
2 I hereby certify that I attended the deceased from <u>Nov 24, 1955</u> , to <u>Dec 1, 1955</u> , that I last saw the deceased alive on <u>Nov 30, 1955</u> , and that death occurred at <u>9:10 A.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>A.S. Chalfant</u>		ADDRESS <u>6210 York Rd Baltimore, Md.</u>	
DATE SIGNED <u>Dec 1, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u>		DATE THEREOF <u>Dec. 1, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Spitler Funeral Home</u>		LOCATION (City, town, or county) (State) <u>Montoursville, Penna.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>3 Dec. 1955</u>		REGISTRAR'S SIGNATURE <u>John Carmichael MacRae</u>	
FUNERAL DIRECTOR <u>John Carmichael MacRae</u>		ADDRESS <u>Towson, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUCKLEY A. E.

SEP 15

RECEIVED
SEP 15 1955

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11606

11611 CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Baltimore</u>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
<input checked="" type="checkbox"/> TOWN <u>Milford</u>	<u>9 Mos.</u>	TOWN <u>Milford</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>3604 Durley Lane</u>		STREET ADDRESS (If rural give location) <u>3604 Durley Lane</u>	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) <u>Robert M.</u> (Middle) <u>Foote</u> (Last) <u>Foote</u>		(Month) <u>Dec.</u> (Day) <u>29</u> (Year) <u>19 55</u>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>Dec. 18, 1879</u>
9. AGE last birthday		10. IF UNDER 1 YEAR	
<u>76</u> yrs.		Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Md.</u>		<u> </u>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<u>George L. Foote</u>		<u>Christina Freund</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
<u>no</u>		<u> </u>	
17. INFORMANT & ADDRESS		18. MEDICAL CERTIFICATION	
<u>Mrs. Mary M. Foote 3064 Durley Lane</u>		I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH IMMEDIATE CAUSE (A) <u>Carcinoma of liver</u> ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronic myocarditis</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Arterio Sclerosis</u> II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
<u> </u>		<u> </u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		21. HOW DID INJURY OCCUR?	
<u> </u>		<u> </u>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
<u> </u>		<u> </u>	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	
<u> </u>		<u> </u>	
21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
<u> </u>		<u> </u>	
22. I hereby certify that I attended the deceased from <u>Mar 10, 19 55</u> to <u>Dec 29, 19 55</u>, that I last saw the deceased alive on <u>Dec 29, 19 55</u>, and that death occurred at <u>4:00 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Paul Brown</u>		DATE SIGNED <u>12/30/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		24. REC'D BY REGISTRAR	
<u>Burial</u>		<u> </u>	
DATE THEREOF		REGISTRAR'S SIGNATURE	
<u>12-31-1955</u>		<u>Dr. Hm. E. Martin</u>	
NAME OF CEMETERY OR CREMATORY		25. FUNERAL DIRECTOR'S SIGNATURE	
<u>Lorraine Park</u>		<u>G. Howard Strong</u>	
LOCATION (City, town, or county) (State)		ADDRESS	
<u>Woodlawn, Md.</u>		<u>3207 W. North Ave.,</u>	

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41

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

11612 CERTIFICATE OF DEATH

11607

Reg. Dist. No. 21

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <u>Woodlawn</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Woodlawn</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1814 Belmont Avenue</u>		STREET ADDRESS (If rural, give location) <u>1814 Belmont Avenue</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>JOHN</u>	(Middle) <u>C.</u>	(Last) <u>FRIZZELL</u>
4. DATE OF DEATH	(Month) <u>Dec.</u>	(Day) <u>21st</u>	(Year) <u>1955</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Sept. 3 1885</u>
9. AGE last birthday <u>70</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Woodlawn, Balto. Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Alfred H. Frizzell</u>		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Mrs John C. Frizzell, 1814 Belmont Ave.</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Coronary Thrombosis</u>		<u>11 Days</u>	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) <u>Arteriosclerotic Cardio Vascular Disease</u>		<u>10 years</u>	
(c) <u>Senility</u>			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Aug 23, 1939</u> to <u>Dec 21, 1955</u> , that I last saw the deceased alive on <u>Dec 21, 1955</u> , and that death occurred at <u>9:15 A.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>Joshua H. Amosoot M.D.</u>		ADDRESS <u>6419 Woodson Hill Rd Baltimore 7 Md</u>	
DATE SIGNED <u>12-22-55</u>			
23. BURIAL, CREMATION REMOVAL. (Specify) <u>Burial</u>		DATE THEREOF <u>Dec. 24 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Mt Olive Cemetery</u>		LOCATION (City, town, or county) <u>Randallstown, Balto. Co. Md</u>	
DATE REC'D BY LOCAL REG. <u>12/22/55</u>		REGISTRAR'S SIGNATURE <u>Phyllis Harman</u>	
ADDRESS <u>4510 Liberty Heights Ave.</u>			

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



11613

CERTIFICATE OF DEATH

Reg. Dist. No. 39

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Baltimore		MARYLAND		STATE Maryland		COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN Monkton Sparks				TOWN Monkton Sparks			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Sparks Road				STREET ADDRESS Sparks Road			
3. NAME OF DECEASED: (Type or Print) JOHN JOSEPH				4. DATE OF DEATH: Dec. 7 1955			
5. SEX: Male		6. COLOR OR RACE: White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married		8. DATE OF BIRTH: July 22, 1888	
9. AGE last birthday: 67 yrs.		10. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: Retired Master Sgt. Sign. Corp. U.S. Army		11. BIRTHPLACE (State or foreign country): New York		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Unknown				14. MOTHER'S MAIDEN NAME: Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or 'unk.'): Yes		16. SOCIAL SECURITY No.: 218-22-0187		17. INFORMANT & ADDRESS: Wilhelmina Gallagher, Sparks, Maryland			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						Interval Between Onset And Death	
Immediate cause (a) Coronary Occlusion						2 min	
Antecedent causes (s) (b) DUE TO							
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c) DUE TO							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION: 11				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21. ACCIDENT (Specify) SUICIDE		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Dec 7, 1955 , to Dec 7, 1955 , that I last saw the deceased alive on Dec 7, 1955 , and that death occurred at 11:30 AM , from the causes and on the date stated above.							
SIGNATURE Dr. M. Francis				DATE SIGNED 12/8/55			
23. BURIAL, CREMATION, REMOVAL (Specify) Burial		DATE THEREOF Dec. 9, 1955		NAME OF CEMETERY OR CREMATORY Baltimore Nat'l. Cemetery		LOCATION (City, town, or county) (State) Baltimore, Maryland	
DATE REC'D BY LOCAL REGISTRAR: 7/10/55		REGISTRAR'S SIGNATURE Dr. Elizabeth Corneil		24. FUNERAL DIRECTOR John Burns, Son		ADDRESS Towson, Maryland	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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MARYLAND

STATE DEPARTMENT OF HEALTH

11614 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH: COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>MD</u> COUNTY <u>BALTO</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>90 HOOD CONVELASANT HOME</u>		STREET ADDRESS (If rural, give location) <u>186 CHERRYDELL RD</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>FLORENCE</u> (Middle) <u>M.</u> (Last) <u>GELLER</u>		4. DATE OF DEATH (Month) <u>12</u> (Day) <u>5</u> (Year) <u>1955</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOW</u>	8. DATE OF BIRTH <u>11-18-1874</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>	9. AGE last birthday <u>81</u> yrs. If under 1 year: Months <u>---</u> Days <u>---</u> Hours <u>---</u> Min. <u>---</u>
11. BIRTHPLACE (State or foreign country) <u>BALTIMORE MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>GEORGE CRAIG</u>		14. MOTHER'S MAIDEN NAME <u>ANNA LOCHNER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) <u>---</u>		16. SOCIAL SECURITY No. <u>---</u>	
17. INFORMANT AND ADDRESS <u>NORTHEA GELLER/186 CHERRYDELL RD</u>			
15. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
422.1 Immediate cause (a).... <u>Myocardial Insufficiency</u>			<u>1 year +</u>
Antecedent cause(s) (b).... <u>Arteriosclerotic Cardio-Vascular Disease</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c).... <u>Fracture, left humerus</u>			<u>2 weeks</u>
II. OTHER SIGNIFICANT CONDITIONS			
Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>---</u>		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT (Specify) <u>---</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>---</u>	
SUICIDE		INJURY	
HOMICIDE		HOW DID INJURY OCCUR?	
TIME (Month) (Day) (Year) (Hour) <u>---</u>		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from <u>Nov. 30, 1955</u> , to <u>Dec. 5, 1955</u> , that I last saw the deceased alive on <u>Dec. 3, 1955</u> , and that death occurred at <u>1:30 A.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>John M. Zimmerman M.D.</u>		ADDRESS <u>3202 Hartford Rd Baltimore</u>	
DATE SIGNED <u>12/5/55</u>			
23. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>		DATE <u>12/8/55</u>	
NAME OF CEMETERY OR CREMATORY <u>LOUNGEY PARK</u>		LOCATION (City, town, or county) (State) <u>17EAKRICK AVE</u>	
DATE REC'D BY LOCAL REG. <u>---</u>		REGISTRAR'S SIGNATURE <u>---</u>	
24. FUNERAL DIRECTOR <u>GEDLEIMBACH</u>		ADDRESS <u>525 N. LYNDA HURST</u>	

MARGIN RESERVED FOR BINDING



1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be examined within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11610

11615

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u> MARYLAND				STATE <u>Maryland</u> COUNTY <u>Baltimore</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Parkton, rural</u>		<u>3 yrs.</u>		TOWN <u>Parkton, rural</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Mt. Carmel Road</u>				STREET ADDRESS (If rural give location) <u>Mt. Carmel Road</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Wilhelmina</u> (Middle) <u>Louise</u> (Last) <u>Gerritz</u>				(Month) <u>Dec.</u> (Day) <u>26</u> (Year) <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Widow</u>	<u>10 Sept. 1892</u>	<u>63</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Factory worker</u>		<u>Paper industry</u>		<u>Germany</u>		<u>USA</u>	
13. FATHER'S NAME <u>Franz Luthe</u>				14. MOTHER'S MAIDEN NAME <u>Anna Bigge</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>no</u>		<u>127-01-2611</u>		<u>Melvin F. Gerritz, Parkton, Md.</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Cerebral Vascular Accident</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hour</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized & Cerebral arteriosclerosis</u>						<u>over 3 yrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>August</u> , 19 <u>55</u> , to <u>December</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>26 Dec</u> , 19 <u>55</u> , and that death occurred at <u>11:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Walter T. Iles</u>		M.D. <u>Cockeysville Md</u>		DATE SIGNED <u>27 Dec 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>30 Dec. 1955</u>		<u>St. Patrick's Cemetery</u>		<u>Watervliet N.Y.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>12-29-55</u>		<u>Mary B. Shive</u>		<u>L. Scott Brooks, Sparks Md.</u>			

U. S. S.

62-101

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11616

CERTIFICATE OF DEATH

11611

38

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTIMORE</u>		STATE <u>MD</u> COUNTY <u>BALTIMORE</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
OR TOWN <u>Joppa PARK</u>		LENGTH OF STAY (In this place) <u>9 yrs</u>		OR TOWN <u>Joppa PARK</u>		OR TOWN <u>Joppa PARK</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>8914 EMLA AVE</u>		STREET ADDRESS (If rural give location) <u>8914 EMLA AVE</u>					
3. NAME OF DECEASED (Type or Print) <u>AGNES</u> (First) <u>GETTIER</u> (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year) <u>12</u> <u>10</u> <u>1955</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Sept. 14, 1888</u>	9. AGE last birthday <u>67</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Joseph HERRING</u>				14. MOTHER'S MAIDEN NAME <u>JULIE HORNICK</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>George E Gettier 8914 EMLA AVE</u> (14)			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
332X IMMEDIATE CAUSE (A) <u>CEREBROVASCULAR DISEASE</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C) <u>Intensive Suburitis</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11/19</u> <u>1955</u> , to <u>12/9</u> <u>1955</u> , that I last saw the deceased <u>alive on</u> <u>12/9</u> <u>1955</u> , and that death occurred at <u>3:42 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Dr. J. M. Smith</u>				DATE SIGNED <u>12/10/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>				24. REC'D BY REGISTRAR <u>Dr. A. M. Bacon</u>			
DATE <u>12-13-55</u>				25. FUNERAL DIRECTOR'S SIGNATURE <u>E. Howard Strong</u>			
				ADDRESS <u>3707 W. North Ave.</u>			

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11617 CERTIFICATE OF DEATH

11612

Reg. Dist. No. 30

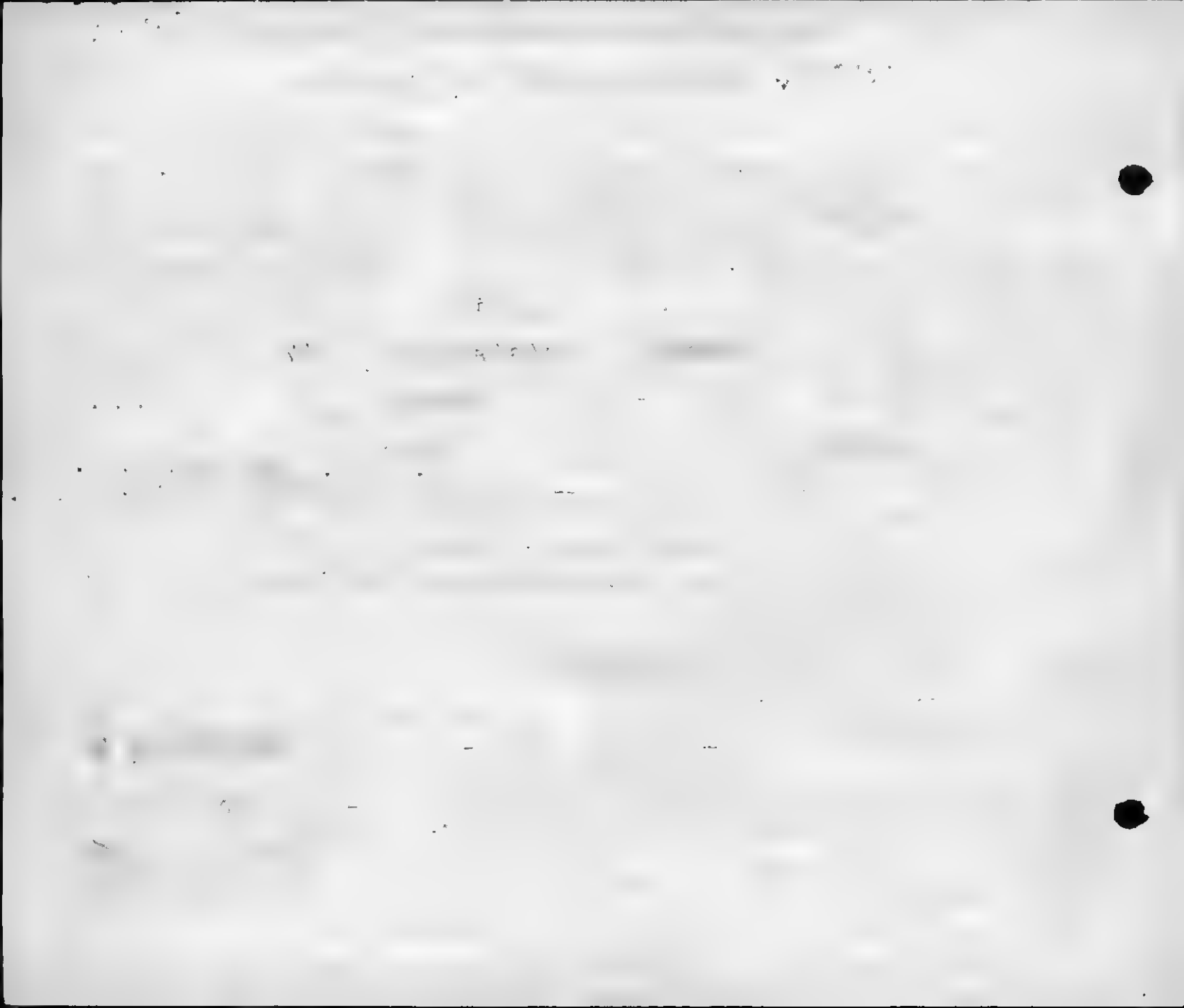
1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u> Co. <u>MARYLAND</u>				STATE <u>Maryland</u> COUNTY <u>Balto. City</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore City</u> <u>77 days</u>				CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore City</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove State Hospital</u> <u>Baltimore 28, Maryland</u>				STREET ADDRESS <u>1802 Eutaw Place (Park Hill Home)</u> <u>Baltimore 17, Maryland</u>			
3. NAME OF DECEASED (Type or Print) <u>Ida</u> <u>A.</u> <u>Gillice</u>				4. DATE OF DEATH (Month) <u>12</u> (Day) <u>5</u> (Year) <u>1955</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>10/13/1878</u>	9. AGE last birthday <u>77</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Patrick Gillice</u>				14. MOTHER'S MAIDEN NAME <u>Ida Lyle</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT'S ADDRESS <u>Baltimore, 28, Md.</u> <u>Spring Grove Hospital Records, Baltimore, Md.</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
422-1 IMMEDIATE CAUSE (A) <u>Congestive heart failure</u>						<u>2 weeks</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic cardiovascular disease</u>						<u>years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Parkinson's syndrome</u>						<u>years</u>	
19a. DATE OF OPERATION <u>---</u>				19b. MAJOR FINDINGS OF OPERATION <u>---</u>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		2D. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/>		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>9-19-55</u> <u>AM</u> , to <u>12-5</u> , 1955, that I last saw the deceased alive on <u>12-5</u> , 1955, and that death occurred at <u>11:50 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Stella Wachler</u>				M.D. <u>Spring Grove St. Hosp</u>		DATE SIGNED <u>12/5/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>burial</u>		DATE THEREOF <u>12/7/55</u>		NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		LOCATION (City, town, or county) <u>Baltimore, Maryland</u>	
24. REC'D BY REGISTRAR DATE <u>---</u>		REGISTRAR'S SIGNATURE <u>T. E. Harry</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm Cook Inc 1217 N. ...</u>		ADDRESS <u>---</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filled with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M



11618

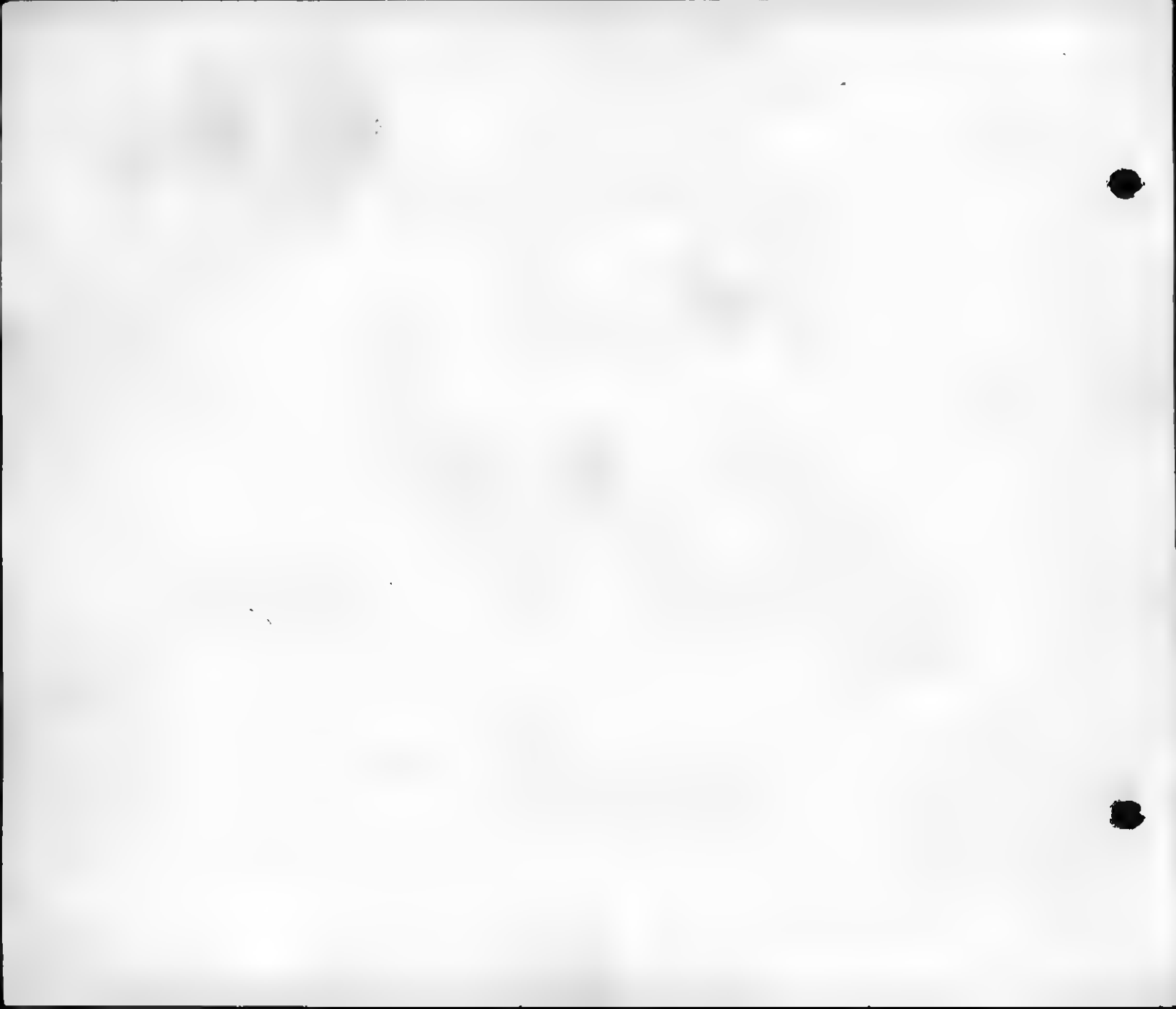
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Baltimore City</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Catonsville</u>	LENGTH OF STAY (in this place) <u>10 years</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>	<u>Y 21 4</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove State Hospital</u>		STREET ADDRESS (If rural give location) <u>1316 W. Lexington Street</u>	
3. NAME OF DECEASED: (Type or Print) <u>WILLIAM GOODMAN</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>Dec 25 1955</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>Sept 17, 1884</u>
9. AGE last birthday <u>71</u> yrs.		10. KIND OF BUSINESS OR INDUSTRY: <u>Gardener</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Gardener</u>		11. BIRTHPLACE (State or foreign country): <u>Queenstown, Maryland</u>	
13. FATHER'S NAME: <u>William Goodman</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>unk</u>		14. MOTHER'S MAIDEN NAME: <u>Mary</u>	
16. SOCIAL SECURITY NO: <u>unknown</u>		17. INFORMANT & ADDRESS: <u>Hospital Records</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Heart Failure</u>			<u>17 days</u>
ANTECEDENT CAUSE (B) <u>Tobacco & Broncho pneumonia</u>			<u>27 days</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Arteriosclerotic Cardiovascular Disease</u>			<u>unknown</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>6</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>11-29</u> , 1955, to <u>12-25</u> , 1955, that I last saw the deceased alive on <u>12-25-55</u> , and that death occurred at <u>5:40</u> P.M., from the causes and on the date stated above.			
SIGNATURE <u>L. Shyne Williams</u>		ADDRESS <u>M.D. Spring Grove State Hosp.</u>	
DATE SIGNED <u>12-25-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Buried</u>		DATE THEREOF <u>Dec 28, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Greenwood</u>		LOCATION (City, town, or county) <u>A.A. to</u>	
DATE REC'D BY LOCAL REGISTRAR <u>12/27/55</u>		REGISTRAR'S SIGNATURE <u>A.A. Hedrick</u>	
FUNERAL DIRECTOR <u>A. Howard Evans</u>		ADDRESS <u>1410 18th Ave</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be filed with the registrar within 24 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11614

11619

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Ellicott City</u>		<u>52 yrs.</u>		TOWN <u>Ellicott City</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>Oella Avenue</u>				<u>Oella Avenue</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>CARLOS</u> (Middle) <u>HOWARD</u> (Last) <u>GORDON</u>				(Month) <u>Dec.</u> (Day) <u>29,</u> (Year) <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Single</u>	<u>October 24, 1903.</u>	<u>52</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Warping</u>		<u>Woolen Mill</u>		<u>Maryland</u>		<u>U. S. A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Charles Howard Gordon</u>				<u>Mary Ethel Brashear</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>213-09-6272</u>		<u>Mrs. M. E. Gordon Oella Ave. Ellicott City, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Carcinoma Pelvic Colon</u>						<u>2 yrs.</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY?	
<u>1 1953</u>		<u>Carcinoma Pelvic Colon - (Colostomy)</u>				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1953</u> to <u>29 Dec 1955</u> , that I last saw the deceased alive on <u>29 Dec 1955</u> , and that death occurred at <u>1:55 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Dr. Mc Grath M.D.</u>				DATE SIGNED <u>12/30/55</u>			
ADDRESS (Street, city, town, state) <u>M.D. 1707 Edmonds Ave Catonsville, Md.</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Jan. 1, 1956</u>		<u>St. Johns Cemetery</u>		<u>Ellicott City, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>1-1-56</u>		<u>T. H. Hartz</u>		<u>Edmonds Ave Catonsville, Md.</u>			

NO. 11

6

JAN

REC-11

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18										11615			
11620										44			
CERTIFICATE OF DEATH										Reg. Dist. No.			
1. PLACE OF DEATH					2. USUAL RESIDENCE (HOME) OF DECEASED								
COUNTY BALTIMORE MARYLAND					STATE MARYLAND COUNTY BALTIMORE								
CITY (If outside corporate limits, write RURAL and give nearest town)					CITY (If outside corporate limits, write RURAL and give nearest town)								
TOWN CHASE					TOWN CHASE								
HOSPITAL OR INSTITUTION OR STREET ADDRESS					STREET ADDRESS (If rural give location)								
GRACE'S QUARTERS RD.					GRACE'S QUARTERS RD.								
3. NAME OF DECEASED (Type or Print)					4. DATE OF DEATH								
(First) (Middle) (Last)					(Month) (Day) (Year)								
ANNA MARIE GRABOWSKI					DEC. 8,			19 55					
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH		9. AGE last birthday		IF UNDER 1 YEAR		IF UNDER 24 HRS	
FEMALE		WHITE		WIDOW		JULY 5, 1872		83 yrs.		Months Days		Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?	
HOUSEWIFE				AT HOME				POLAND				U. S. A.	
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME								
MICHAEL MACHOWIAK					MARY UNKNOWN								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)					16. SOCIAL SECURITY NO.					17. INFORMANT & ADDRESS			
NO					NONE					MICHAEL L. GRABOWSKI CHASE, MD.			
18. MEDICAL CERTIFICATION													
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH													
422.1 IMMEDIATE CAUSE (A) Cerebro-Vascular accident													
ANTECEDENT CAUSE(S) DUE TO (B) Arteriosclerotic Cardiovascular Disease													
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)													
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.													
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)				21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)				21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from Dec 5, 1955, to Dec 8, 1955, that I last saw the deceased alive on Dec 8, 1955, and that death occurred at 3 P.M. from the causes and on the date stated above.													
SIGNATURE						ADDRESS (Street, city, town, state)			DATE SIGNED				
M. B. Gardner						M.D. Balto 6 Md			12/9/55				
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY				LOCATION (City, town, or county) (State)					
BURIAL		12-12-1955		SACRED HEART OF MARY				BALTIMORE, MD.					
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE				25. FUNERAL DIRECTOR'S SIGNATURE				ADDRESS			
DEC 13 1955		Dawson L. Larkins				Lorraine Funeral Home - 7401 Belair Rd.							

WILLIAM V. S.

1955

RECEIVED

11621 CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Baltimore</u>
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	
<u>X</u>	<u>27 yrs.</u>	<u>5</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Rosewood State Training School Owings Mills, Maryland.</u>		STREET ADDRESS (If rural give location) <u>Dembarton House, Towson - 4, Md.</u>	
3. NAME OF DECEASED: (Type or Print)		4. DATE OF DEATH:	
(First) (Middle) (Last)		(Month) (Day) (Year)	
<u>Lois Alexina Gray</u>		<u>12 15 1955</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:
<u>female</u>	<u>white</u>	<u>single</u>	<u>8/13/18</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	9. AGE last birthday
<u>none</u>		<u>—</u>	<u>37</u> yrs.
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Baltimore Co., Md.</u>		<u>USA</u>	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<u>Frederick VonKapff Gray</u>		<u>Lula Crossmore</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		17. INFORMANT & ADDRESS:	
<u>no</u>		<u>Rosewood records</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Acute Bronchitis - Bronchial pneumonia.</u>			<u>5 days</u>
ANTECEDENT CAUSE (B) <u>Quadruplegia - etiology undetermined.</u>			<u>Since birth</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Epilepsy - etiology undetermined.</u>			<u>" "</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Microcephaly.</u>			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
<u>6</u>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
<input type="checkbox"/>		<input type="checkbox"/>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>2/15/28</u> to <u>2/15/1955</u> , that I last saw the deceased alive on <u>2/15</u> , 19 <u>55</u> , and that death occurred at <u>12:50 M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Harry H. Budler</u>		ADDRESS <u>Owings Mills, Md.</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	
<u>BURIAL</u>		<u>DEC. 17, 1955</u>	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
<u>PARKWOOD CEMETERY</u>		<u>PARKVILLE, MD.</u>	
DATE REC'D BY LOCAL REGISTRAR		24. FUNERAL DIRECTOR	
<u>12-16-55</u>		<u>Mary B. Zline</u>	
REGISTRAR'S SIGNATURE		ADDRESS	
		<u>John Burns Lane Towson</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 22 1955

BUREAU V. S.

11622 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u> MARYLAND				STATE <u>Maryland</u> COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Fort Howard</u> LENGTH OF STAY (in this place) <u>23</u> days				CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location) <u>3308 Elgin Avenue</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>GEORGE E. GREEN</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>December 20, 19 55</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>12/9/90</u>	
9. AGE last birthday <u>65</u> yrs		10. MONTHS <u>12</u> DAYS <u>9</u> HOURS <u>31</u> MIN.		9. AGE last birthday <u>65</u> yrs		10. MONTHS <u>12</u> DAYS <u>9</u> HOURS <u>31</u> MIN.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Clerical</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>Insurance</u>			
11. BIRTHPLACE (State or foreign country): <u>Woodensburg, Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME: <u>Jacob E. Green</u>				14. MOTHER'S MAIDEN NAME: <u>Emma E. Morrison</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes WW I</u>				16. SOCIAL SECURITY NO. <u>216-09-1306</u>			
17. INFORMANT & ADDRESS: <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>							
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>CARCINOMATOSIS</u>							
ANTECEDENT CAUSE (B) <u>CARCINOMA, STOMACH</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>2</u>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)			
21C. WHERE DID (City or town) (County) (State)				21D. HOW DID INJURY OCCUR?			
21E. TIME (Month) (Day) (Year) (Hour) (Minute) OF INJURY				21F. HOW DID INJURY OCCUR?			
21G. WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> at work at work							
2. I hereby certify that I attended the deceased from Nov. 27, 1955, to Dec. 20, 1955, that I saw the deceased alive on <u>Nov. 27, 1955</u> and that death occurred at <u>6:31 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>GEORGE LERNER</u>				ADDRESS <u>Fort Howard, Md.</u>			
DATE SIGNED <u>12/20/55</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				24. FUNERAL DIRECTOR ADDRESS			
DATE REC'D BY LOCAL REGISTRAR <u>12-22-55</u>				REGISTRAR'S SIGNATURE <u>[Signature]</u>			
NAME OF CEMETERY OR CREMATORY <u>Mount Gilead Cemetery</u>				LOCATION (City, town, or county) (State) <u>Woodsburg, Md.</u>			
DATE REC'D BY LOCAL REGISTRAR <u>12-22-55</u>				FUNERAL DIRECTOR ADDRESS <u>Wm. J. Tickner & Sons, Inc. North & E. Ave., Baltimore, Md.</u>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

11618

11551

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH - COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE Md. COUNTY 1	
CITY (If outside corporate limits, write RURAL and give nearest town) Arbutus		CITY (If outside corporate limits, write RURAL and give nearest town) Arbutus	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 5503 Council St.		STREET ADDRESS (If rural, give location) 5503 Council St.	
3. NAME OF DECEASED (Type or Print) Peter	(First)	(Middle)	(Last)
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	4. DATE OF DEATH Dec. 5 1955
8. DATE OF BIRTH May 19, 1903		9. AGE last birthday 52 Yrs. 6 Months 5 Days 19 Hours 55 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Boiler Maker		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Andrew Green		14. MOTHER'S MAIDEN NAME Anna Senca	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. 163-05-9554	
17. INFORMANT AND ADDRESS Gladys R. Green 5503 Council St.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1

Immediate cause

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

Myocardial Infarction
Coronary Occlusion
Circulatory Disturbance

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office hldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **12/2**, 19**53**, to **12/5**, 19**55**, that I last saw the deceased

alive on **12/2**, 19**55**, and that death occurred at **7:30** m., from the causes and on the date stated above.

SIGNATURE *[Signature]* ADDRESS **1305 Francis Ave.** DATE SIGNED **12/5/55**

23. BURIAL CREMATION REMOVAL (Specify) Burial		DATE THEREOF Dec. 8, 1955	NAME OF CEMETERY OR CREMATORY Glen Haven	LOCATION (City, town, or county) Ritchie Highway	(State)
DATE REC'D BY LOCAL REG. 12/5/55		REGISTRAR'S SIGNATURE <i>[Signature]</i>		24. FUNERAL DIRECTOR <i>[Signature]</i> ADDRESS 1913 W. Balto. St.	

MARGIN RESERVED FOR BINDING

VS. A15



11623

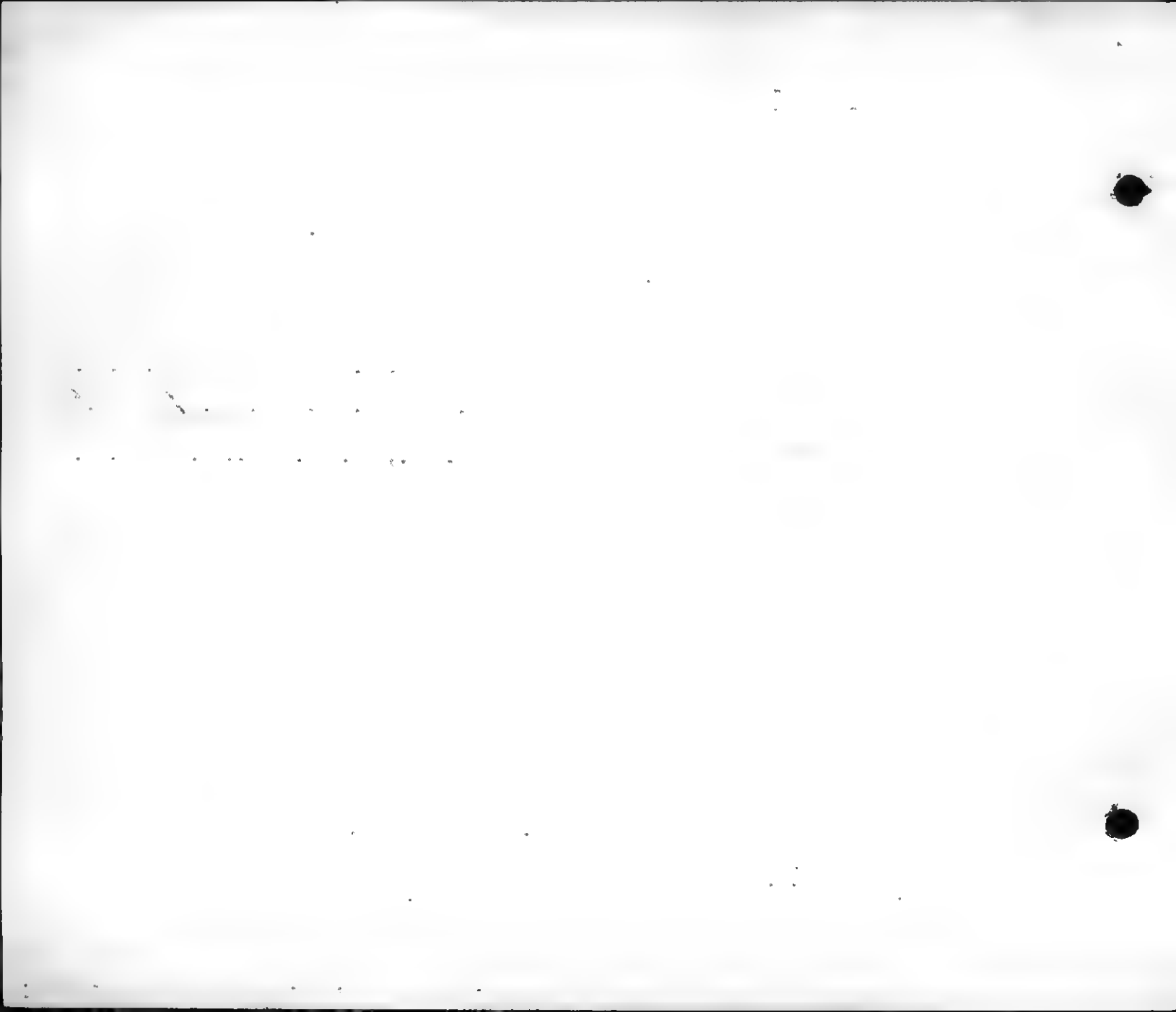
CERTIFICATE OF DEATH

Reg. Dist. No. *XX*

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>XX</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>TOWN Fort Howard</u>		LENGTH OF STAY (in this place) <u>4 Days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>TOWN Baltimore</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location) <u>7847 St. Fabian Way</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>HOMER D. GRIMM</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>December 15 19 55</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>Divorced</u>	8. DATE OF BIRTH: <u>2-5-98</u>	9. AGE last birthday: <u>57</u> yrs.	IF UNDER 1 YEAR: Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Painter</u>			10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Terra Alta, W. Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13. FATHER'S NAME: <u>George Grimm</u>				14. MOTHER'S MAIDEN NAME: <u>Lucy Methaney</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes WW I</u>				16. SOCIAL SECURITY NO. <u>234-12-0498</u>		17. INFORMANT & ADDRESS: <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>PULMONARY EMPHYSEMA</u>						UNKNOWN	
ANTECEDENT CAUSE (S) DUE TO <u>ASTHMA, CHRONIC</u>						UNKNOWN	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (B) DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>C</u>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec. 11, 1955</u> to <u>Dec. 15, 1955</u> , that I last saw the deceased <u>XXXXXX</u> and that death occurred at <u>5:40 P.M.</u> from the causes and on the date stated above. SIGNATURE <u>Francis G. Dickey</u> ADDRESS <u>M. D. VAH, FT. HOWARD, MARYLAND</u> DATE SIGNED <u>12-16-55</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12-19-55</u>		NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>12-19-55</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR ADDRESS <u>Wm. Cook-Blight, Inc., 6009 Harford Rd., Balt., Md.</u>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



Item 8: Film G191 1/16/58 dmr

Item 9:

11624

CERTIFICATE OF DEATH

Reg. Dist. No. 37

Item 2: Film G190 1-3-56 et.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Ma</u>		COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Cockeysville</u>		<u>5 years.</u>		TOWN <u>Cockeysville</u>		<u>Essex 21</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Balto. Co. Home</u>				STREET ADDRESS (If rural give location) <u>125 Riverside Ave.</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>William D Guthrie</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>12/23/55</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>1875 Aug. 6, 1907/1</u>	9. AGE last birthday <u>78</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor-work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John A. Guthrie</u>				14. MOTHER'S MAIDEN NAME <u>Ada Price</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>unk.</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Frank C. Bobant - 125 Riverside Ave. Essex 21</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH <u>at least 3 years.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
4. IMMEDIATE CAUSE (A) <u>Generalized Arteriosclerosis</u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb. 7, 1953</u> to <u>Dec. 23, 1955</u> , that I last saw the deceased alive on <u>Dec. 22, 1955</u> , and that death occurred at <u>5:15 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Elizabeth B. Sherrill</u> M.D.				ADDRESS (Street, city, town, state) <u>Cockeysville, Maryland</u>		DATE SIGNED <u>12/23/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12-27-55</u>		NAME OF CEMETERY OR CREMATORY <u>Oak Lawn</u>		LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Wm. J. Whitehead</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John F. Connelly</u>		ADDRESS <u>Essex Md.</u>	
DATE <u>12/23/55</u>							

INSTRUCTIONS TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A19C 1-55 10M

BUREAU V. S.

DEC 2 195

RECEIVED

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11621

MARYLAND STATE DEPARTMENT OF HEALTH

11625

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 30

1. PLACE OF DEATH- COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Balto	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Catonsville LENGTH OF STAY (4 years)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Upperco	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Spring Grove State Hospital		STREET ADDRESS (If rural, give location) /	
3. NAME OF DECEASED (Type or Print)	(First) Cora (Middle) Foster (Last) Hale	4. DATE OF DEATH (Month) (Day) (Year) Dec. 10, 1955	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 1/17/98
9. AGE last birthday 57 ym.		10. AGE last birthday (If under 1 year) Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Hoffman		14. MOTHER'S MAIDEN NAME Annie Peregory	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS Records: Spring Grove State Hospital			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
<p>902.7 Immediate cause (a) Subdural organizing hematoma</p> <p>Antecedent cause(s) (b) Cerebral laceration scar left frontal lobe</p> <p>(c) Huntington's Chorea</p>			
11. OTHER SIGNIFICANT CONDITIONS			
Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY Hospital	(CITY OR TOWN) Catonsville	(COUNTY) Balto (STATE) MD
TIME (Month) (Day) (Year) (Hour) OF INJURY 9 2 53 P m.	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? Fell out of bed	
22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> accident <input checked="" type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/>			
SIGNATURE Wm. McKieffer MD (Degree or title)		ADDRESS 1010 Lead Ave. Blue 11-55	
23. DATE OF CREMATION (Specify)	DATE THEREOF 12-18-55	NAME OF CEMETERY OR CREMATORY Mt Carmel	LOCATION (City, town, or county) (State) Balto. Co
DATE REC'D BY LOCAL REG. 12-11-55	REGISTRAR'S SIGNATURE V. E. Harry	24. FUNERAL DIRECTOR Edward C. Tipton ADDRESS Hempstead, Md	

MARGIN RESERVED FOR DAWING

EASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3. A. 1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 **11622**
11626 CERTIFICATE OF DEATH

Reg. Dist. No. **33**

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Baltimore		MARYLAND		STATE Maryland COUNTY Harford			
CITY (If outside corporate limits, write RURAL OR and give nearest town) Owings Mills		LENGTH OF STAY (in this place) 11 yrs.		CITY (If outside corporate limits, write RURAL and give nearest town) Havre de Grace			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Rosewood Training School				STREET ADDRESS (If rural give location) Rural Webster			
3. NAME OF DECEASED: (First) (Middle) (Last) Lois - Hamilton				4. DATE (Month) (Day) (Year) OF DEATH: 12 9 19 55			
5. SEX: female	6. COLOR OR RACE: white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single	8. DATE OF BIRTH: 2/2/34	9. AGE last birthday 21 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):			10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Charles Hamilton				14. MOTHER'S MAIDEN NAME: Ozella Phillips			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: Rosewood Records	
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Asphyxia (aspiration food)				5 min.			
ANTECEDENT CAUSE (B) Encephalitis (mucous) with							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) Symptomatic Epilepsy				20 yrs &			
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR COND. CAUSING DEATH.				10 mos.			
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 12/1 , 19 55 , to 12/9 , 19 55 that I last saw the deceased alive on 12/9 , 19 55 , and that death occurred at 12:45 P.M. from the causes and on the date stated above.							
SIGNATURE Harry B. Butler M.D.				ADDRESS Owings Mills, Md. 10 Dec 55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		Dec. 12 - 1955		Wesleyan Chapel Cemetery		Cherchen Rural Md	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
Dec. 11 - 55		Mary Oliver		John G. Garrison		Cherchen Md	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

DEC 14 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

11623

Reg. Dist. No. 37

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Penn a.</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>241 West May St. / 18th St.</u> LENGTH OF STAY (in this place) <u>8 hours</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Glenside Route #1.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Timonium</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (First) <u>Clude</u> (Middle) (Last) <u>Harrell</u>		4. DATE OF DEATH (Month) <u>December</u> (Day) <u>23</u> (Year) <u>1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>5/28/1930</u>
10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) <u>Martha Street</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>	9. AGE last birthday <u>25</u> yrs. If under 1 year: Months <u>23</u> Days <u>12</u> Hours <u>55</u>
11. FATHER'S NAME <u>Wilder Harrell</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. WAS DECEASED BORN IN U.S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		14. SOCIAL SECURITY No. <u>170-24-2162</u>	
15. INFORMANT AND ADDRESS <u>Wm. Harrell - Glen Rock, Pa.</u>		16. MOTHER'S MAIDEN NAME <u>Martha Street</u>	
17. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 711.3 Immediate cause (a) <u>Intracranial Hemorrhage</u> Antecedent cause(s) (b) <u>from fractured skull</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH? <input type="checkbox"/>		PLACE (Home, farm, factory, street, office bldg., etc.) <u>Lutherville</u> (CITY OR TOWN) <u>Baltimore</u> (COUNTY) <u>Maryland</u> (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>December 22, 1955</u>		INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/> HOW DID INJURY OCCUR? <u>Tree limb (516) fell 100 ft on head</u>	
22. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry, thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes, accident, suicide, homicide, undetermined.			
SIGNATURE <u>Robert O'Donnell M.D.</u> (Degree or title)		ADDRESS <u>7501 York Rd Towson #4 Md.</u>	
DATE THEREOF <u>12/23/55</u>		NAME OF CEMETERY OR CREMATORY <u>St. Joseph's Home</u>	
DATE RECEIVED BY LOCAL REG. <u>27 December 1955</u>		LOCATION (City, town, or county) <u>Glen Rock, Pa.</u> (State) <u>Pa.</u>	
REGISTRAR'S SIGNATURE <u>Ann Amis</u>		FURNERAL DIRECTOR'S ADDRESS <u>St. Joseph's Home Glen Rock, Pa.</u>	

11-11-11

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INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AHC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11628 **CERTIFICATE OF DEATH**

11624

Reg. Dist. No. 30

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Baltimore		MARYLAND		STATE Ma.		COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Catonsville		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Catonsville			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 818 Braeside Rd				STREET ADDRESS (If rural give location) 922 Masfield Rd			
3. NAME OF DECEASED (First) (Middle) (Last) John R. Haubert				4. DATE OF DEATH (Month) (Day) (Year) Dec. 31/55			
5. SEX M.	6. COLOR OR RACE N.	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Jan. 12, 1890		9. AGE last birthday 65 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME John Fred Haubert				14. MOTHER'S MAIDEN NAME Elizabeth Thome			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213 03 9492		17. INFORMANT & ADDRESS Mrs. Marie K. Haubert			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) CHRONIC MYOCARDITIS.						3 YEARS	
ANTECEDENT CAUSE(S) DUE TO (B) ARTERIOSCLEROSIS.....						4. . .	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION 0 0		19b. MAJOR FINDINGS OF OPERATION 0				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) 0		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) 0			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 0		21e. INJURY OCCURRED While at work Not while at work M. <input type="checkbox"/> <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from JULY 31, 1952, to Jan. 1, 1956, that I last saw the deceased alive on Dec. 16, 1955, and that death occurred at M, from the causes and on the date stated above.							
SIGNATURE <i>[Signature]</i>				ADDRESS (Street, city, town, state) M.D. 6348 FREDERICK ROAD. BALTO 28		DATE SIGNED 1/3/56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Jan. 4/56		NAME OF CEMETERY OR CREMATORY Baltimore National		LOCATION (City, town, or county) (State) Baltimore, Md.	
24. REC'D BY REGISTRAR DATE 1-3-56		REGISTRAR'S SIGNATURE <i>[Signature]</i>		DEPUTY REGISTRAR'S SIGNATURE <i>[Signature]</i>		ADDRESS 4101 EDMONDSON AVE	

BUREAU V. B.

JAN 5 1956

RECEIVED

PLAIN TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 181625

11552

CERTIFICATE OF DEATH

Reg. Dist. No. 42

Item 2 FilmG191 1-11-56 et

1. PLACE OF DEATH.		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Baltimore	MARYLAND	STATE Maryland	COUNTY Baltimore
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Halethorpe	LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Halethorpe Pikesville 8	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Craddock Home		STREET ADDRESS 7126 Walnut Avenue Craddock Home (Northeast Ave.)	
3. NAME OF DECEASED: (First) (Middle) (Last) MARTHA HAWKINS		4. DATE (Month) (Day) (Year) OF DEATH: Dec. 29, 1955	
5. SEX: Female	6. COLOR OR RACE: Colored	7. SINGLE. MARRIED. WIDOWED. DIVORCED. Widow	8. DATE OF BIRTH: Jan. 4, 1885
9. AGE last birthday: 70 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: John Harris		14. MOTHER'S MAIDEN NAME: Anna Robinson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. MARRIAGE: Mrs. Bessie Harris		18. 3910 Brown Street W. Phila. Pa.	
19. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) Cardiovascular Disease			
ANTECEDENT CAUSE (B) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21E. TIME (Month) (Day) (Year) (Hour) OF INJURY		21F. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
22. I hereby certify that I attended the deceased from Oct 13, 1955 , to Dec 28, 1955 , that I last saw the deceased alive on Dec 28, 1955 , and that death occurred at 3:45 P M, from the causes and on the date stated above.			
SIGNATURE W. D. R. W.		DATE SIGNED 27	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Jan. 1, 1955	
NAME OF CEMETERY OR CREMATORY Family lot		LOCATION (City, town, or county) (State) Brays, Va.	
DATE REC'D BY LOCAL REGISTRAR 31. 1955		REGISTRAR'S SIGNATURE R. W.	
24. WILLIAM S. GIBSON, Sr.		ADDRESS 1735 Druid Hill Ave.	



11626

MARYLAND STATE DEPARTMENT OF HEALTH

11629 CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No.

1. PLACE OF DEATH- COUNTY Baltimore		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Md. COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Middle River		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Glen L. Martin Co. Eastern Blvd.		STREET ADDRESS (If rural, give location) 2610 Talbot Road (16)	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) George Ambrose Hayes, Sr.		4. DATE OF DEATH (Month) (Day) (Year) Dec. 6, 1955	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 12/27/1900
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laboratory Technician		10b. KIND OF BUSINESS OR INDUSTRY Electronics	9. AGE last birthday 54 yrs.
11. BIRTHPLACE (State or foreign country) Pa.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Jesse S. Hayes		14. MOTHER'S MAIDEN NAME Sarah Elizabeth Lucore	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 072-16-0095	
17. INFORMANT Lillian F. Hayes 2610 Talbot Rd.			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

4221
Immediate cause

(a)

Coronary Occlusion

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

INTERVAL BETWEEN ONSET AND DEATH

5 min

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.PLACE (Home, farm, factory, street, office, etc.) OF INJURY *W*

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at work ☐ Nat while at work ☐

HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

*12-5-55**Dr. J. H. Strong**G. Howard Strong 3207 W. North Ave.*

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1/11/1911

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75

107 1/2 1200

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

11627

11630

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rockdale</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rockdale</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>3074 Milford Hill Rd.</u>		STREET ADDRESS (If rural, give location) <u>3074 Milford Hill Rd.</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Edna</u> <u>F.</u> <u>Herman</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Dec.</u> <u>25</u> <u>1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Oct 23, 1890</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	9. AGE last birthday <u>65</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>E. Herman</u>		14. MOTHER'S MAIDEN NAME <u>May Morey</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>718-05-4424</u>	
17. INFORMANT AND ADDRESS <u>Edna Herman, 3074 Milford Hill Rd.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>10 years</u>
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Acute Congestive Heart Failure</u>	Antecedent cause(s) (b) <u>Pulmonary Edema - severe</u> (c) <u>Chronic Arteriosclerosis</u>	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct. 15, 1955, to Dec. 25, 1955, that I last saw the deceased alive on Dec. 25, 1955, and that death occurred at 10:00 a.m., from the causes and on the date stated above.

SIGNATURE <u>Edna Herman</u>	(Degree or title) <u>MD</u>	ADDRESS <u>Davidson House, Md.</u>	DATE SIGNED <u>12/26/55</u>
23. BURIAL CEMETERY OR CREMATORY REMOVAL (Specify) <u>Rockdale</u>	DATE <u>Dec. 25, 1955</u>	NAME OF CEMETERY OR CREMATORY <u>Rockdale Cemetery</u>	LOCATION (City, town, or county) (State) <u>Rockdale, Anne Arundel Co. Md.</u>
DATE REC'D BY LOCAL REG. <u>12-28-55</u>	REGISTRAR'S SIGNATURE <u>Edna Herman</u>	24. FUNERAL DIRECTOR <u>Edna Herman</u>	ADDRESS <u>4510 Liberty Highway, Baltimore</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



11631 **CERTIFICATE OF DEATH**Reg. Dist. No. 30

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTO. CO</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>BALTO. CO</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>CATONSVILLE</u>		<u>240</u>		TOWN <u>CATONSVILLE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>RIDGEWAY MANOR</u>				STREET ADDRESS (If rural give location) <u>4 HEIGHTS ALE</u>			
3. NAME OF DECEASED (Type or Print) <u>FRANK</u> (First) <u>H. NSBT</u> (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year) <u>12/19/55</u> 19			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOW</u>	8. DATE OF BIRTH <u>Feb 3, 1883</u>		9. AGE last birthday <u>72</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>S. ARMT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>		11. BIRTHPLACE (State or foreign country) <u>ARK.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>—</u>				14. MOTHER'S MAIDEN NAME <u>—</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> <u>WWI</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT & ADDRESS <u>ALFRED HENSBT, SON</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
420.1 IMMEDIATE CAUSE (A) <u>Cancer, Thrombosis & failure</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronic sclerosis generalized</u>						<u>subacute</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July</u> , 19 <u>52</u> , to <u>Dec</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Nov</u> , 19 <u>55</u> , and that death occurred at <u>5:15</u> AM, from the causes end on the date stated above.							
SIGNATURE <u>Chiff</u>				ADDRESS (Street, city, town, state) <u>M.D. 4605 Edmonson ave</u>			
DATE SIGNED <u>12/20/55</u>				DATE SIGNED <u>12/20/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>12/21/55</u>		NAME OF CEMETERY OR CREMATORY <u>U.S. NATIONAL</u>		LOCATION (City, town, or county) <u>BALTO MD</u>	
24. REC'D BY REGISTRAR <u>12/20/55</u>		REGISTRAR'S SIGNATURE <u>V.E. Harvey</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. H. H. + Son</u>		ADDRESS <u>25</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

BUREAU V. S.

DEC 27

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11629

11632

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		STATE <u>Maryland</u>		COUNTY <u>1</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Fort Howard</u>		<u>58 Days</u>		TOWN <u>Baltimore</u> (21)		57	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location) <u>320 Homberg Avenue</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) <u>VICTOR</u> (Middle) <u>HERFEL</u> (Last)				<u>December 29,</u> 19 <u>55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Single</u>	<u>October 1, 1888</u>	<u>67</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Photographer</u>		<u>Passport Identification</u>		<u>Baltimore, Maryland</u>		<u>U. S. S. A.</u>	
13. FATHER'S NAME <u>George Herfel</u>				14. MOTHER'S MAIDEN NAME <u>Emily Gerding</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>Yes</u> <u>WW I</u>		<u>Unknown</u>		<u>Clin. Rec. Vet. Adm. Hosp., Ft. Howard, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
1. IMMEDIATE CAUSE (A) <u>AORTIC VALVULAR DISEASE WITH DECOMPENSATION</u>				INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u>			
2. ANTECEDENT CAUSE(S) DUE TO <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u>				<u>UNKNOWN</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov. 1</u> , 19 <u>55</u> , to <u>Dec. 29</u> , 19 <u>55</u> , and that death occurred at <u>8:10 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Francis G. Dickey</u>				ADDRESS (Street, city, town, state) <u>FORT HOWARD, MARYLAND</u> DATE SIGNED <u>12-29-55</u>			
Francis G. Dickey, I.D. Chief, Medical Service							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>1/2/57</u>		<u>Oak Lawn Cemetery</u>		<u>Baltimore, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>James J. Pruzdzinski</u>		<u>James J. Pruzdzinski</u>		<u>James J. Pruzdzinski</u>		<u>Baltimore</u>	
DATE <u>JAN 2 1957</u>		<u>Lawson L. Larkins</u>		<u>James J. Pruzdzinski</u>		<u>1407 Eastern Ave. Md.</u>	

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11631

MARYLAND

STATE DEPARTMENT OF HEALTH

11633

CERTIFICATE OF DEATH

Reg. Dist. No. 33

Item 8. Film G191 1-11-56 et

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Owings Mills</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Owings Mills</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Pleasant Hill Park</u>		STREET ADDRESS (If rural, give location) <u>Pleasant Hill Park</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>WILLIAM</u> <u>FREDERICK</u> <u>HINKHAUS</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>December 31</u> <u>1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>April 23/1878</u>
10a. USUAL OCCUPATION (Give kind of work done during last of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Nothing</u>	9. AGE last birthday <u>79</u> yrs.
11. FATHER'S NAME <u>Frederick Hinkhaus</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. MOTHER'S MAIDEN NAME <u>Elizabeth Foster</u>		14. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If year, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>cannot locate</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Joseph Wolford, Owings Mills Md</u>		18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a).... <u>Congestive Heart Failure</u>		<u>2 weeks</u>	
Antecedent cause(s) (b)....			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)....			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. ACCIDENT SUICIDE HOMICIDE (Specify)		21. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from <u>November, 1954</u> to <u>Dec. 31, 1955</u> , that I last saw the deceased alive on <u>Dec 31, 1955</u> , and that death occurred at <u>5:30 A.M.</u> , from the causes and on the date stated above.		23. HOW DID INJURY OCCUR?	
SIGNATURE <u>Clarence E. McWilliams</u> (Degree or title)		DATE SIGNED <u>Dec 31/1955</u>	
24. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		NAME OF CEMETERY OR CREMATORY <u>Pleasant Hill Cemetery</u>	
DATE REC'D BY LOCAL REG. <u>12-31-55</u>		LOCATION (City, town, or county) (State) <u>Owings Mills Md.</u>	
REGISTRAR'S SIGNATURE <u>Mary D. Zinke</u>		25. FUNERAL DIRECTOR <u>Wm. Bergman & Sons, Reisterstown, Md.</u>	

MARGIN RESERVED FOR BINDING

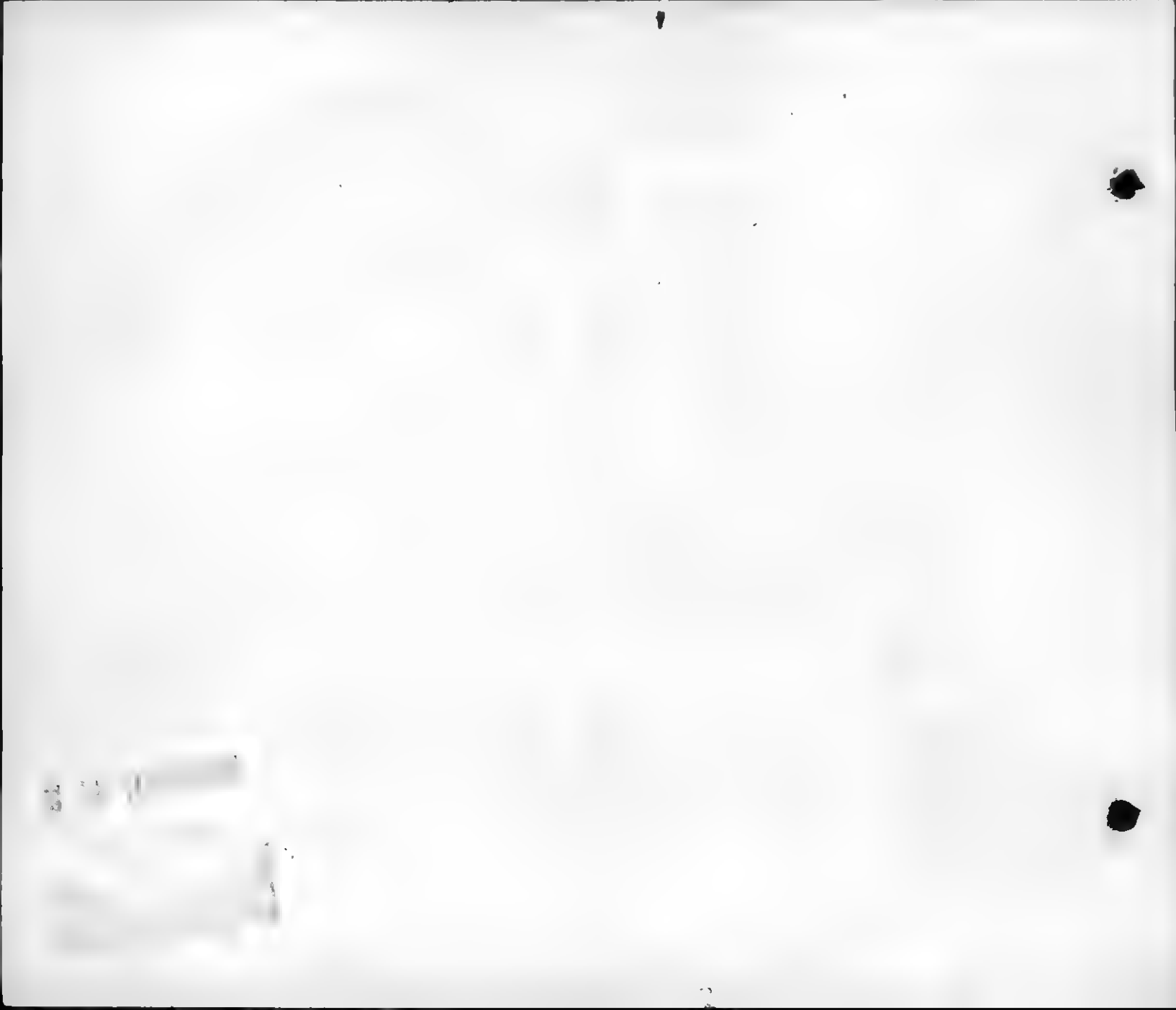
3 NOV 1962

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100-2054

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18				11631
Item 18: Film G193 3-2-56 amg				11634
CERTIFICATE OF DEATH				Reg. Dist. No. 83
1. PLACE OF DEATH.		2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <u>Baltimore</u> MARYLAND		STATE <u>Maryland</u> COUNTY		
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		
TOWN <u>Baltimore</u>		TOWN <u>Baltimore</u>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Rosewood St. M. School</u>		STREET ADDRESS (If rural give location) <u>3907 Mondawmin Ave</u>		
12. HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Owings Mills, Md.</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		
3. NAME OF DECEASED: (First) <u>Alice</u> (Middle) <u>Jeanne</u> (Last) <u>Hoffman</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>12</u> <u>24</u> <u>1955</u>		
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>white</u>		
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>		8. DATE OF BIRTH: <u>12/15/53</u>		
9. AGE last birthday: <u>2</u> yrs.		10. BIRTHPLACE (State or foreign country): <u>Maryland</u>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		
13. FATHER'S NAME: <u>Morris Joseph Hoffman</u>		14. MOTHER'S MAIDEN NAME: <u>Edith Muskat</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>—</u> (If Yes, give war or dates of service): <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>		
17. INFORMANT & ADDRESS: <u>Rosewood Records</u>		18. MEDICAL CERTIFICATION		
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH		
IMMEDIATE CAUSE <u>492X</u>		<u>Acute pneumonia</u>		
ANTECEDENT CAUSE (B):		(A) <u>Pulmonary edema</u>		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		DUE TO <u>Aspiration of mucus and saliva</u>		
		DUE TO <u>colored blood - (guttus viscus)</u>		
		(C) <u>Complete dissection - (guttus viscus)</u>		
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		<u>Mongolism (Microcephaly, small cerebellum)</u>		
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <u>9-16</u> , 19 <u>54</u> to <u>12-24</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12-24</u> , 19 <u>55</u> , and that death occurred at <u>5:10 A.M.</u> , from the causes and on the date stated above.				
SIGNATURE <u>Viola B. Johns</u>		ADDRESS <u>M. D. Rosewood St. Dr. Sch. Owings Mills, Md.</u>		DATE SIGNED <u>12/24/55</u>
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12-26-55</u>		NAME OF CEMETERY OR CREMATORY <u>Baltimore Hebrew</u>
				LOCATION (City, town, or county) (State) <u>Balto Md</u>
DATE REC'D BY LOCAL REGISTRAR <u>DEC 26 1955</u>		REGISTRAR'S SIGNATURE <u>Walter Lewis Inc</u>		24. FUNERAL DIRECTOR ADDRESS <u>2100 Eutaw Pl</u>



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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-53 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11635

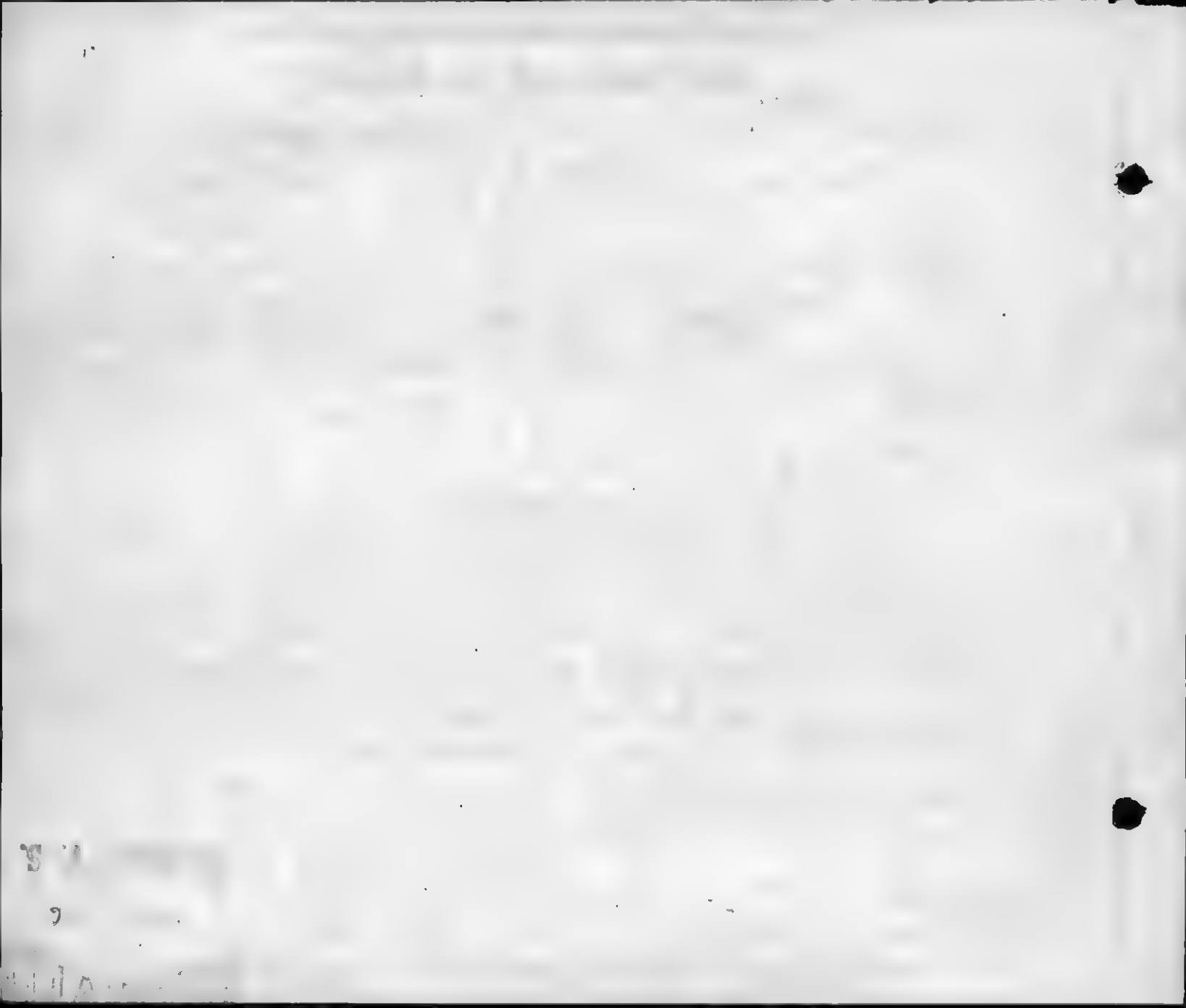
CERTIFICATE OF DEATH

11632

30

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND CITY OR TOWN <u>Catonsville</u> LENGTH OF STAY (in this place) <u>4 mo 14 days</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove State Hospital</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md</u> COUNTY <u>Essex</u> CITY OR TOWN <u>Dundalk, 22</u> STREET ADDRESS <u>6728 Penn Ave.</u>			
3. NAME OF DECEASED (Type or Print) (First) <u>Percy</u> (Middle) <u>—</u> (Last) <u>Hollingsworth</u>				4. DATE OF DEATH (Month) <u>12</u> (Day) <u>- 30</u> (Year) <u>19 55</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>4/25/1886</u>	9. AGE last birthday <u>69</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>never worked</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>unknown</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>unk.</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>ADK.</u>		17. INFORMANT & ADDRESS <u>This Hospital's Records</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
142.1 IMMEDIATE CAUSE (A) <u>Terminal pneumonia</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Multiple Generalized Metastases</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Malignant neoplasm of salivary gland</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>2</u>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <u>August 16, 19 55</u> , to <u>December 30, 19 55</u> , that I last saw the deceased alive on <u>12/29, 19 55</u> , and that death occurred at <u>3:34 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Bruno Radauskas</u> M.D. <u>Spring Grove State Hospital</u>				ADDRESS (Street, city, town, state) <u>Baltimore, Md.</u> DATE SIGNED <u>12/30/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Buried</u>		DATE THEREOF <u>1-3-56</u>		NAME OF CEMETERY OR CREMATORY <u>PAK LAWN</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
24. REC'D BY REGISTRAR <u>JAN 2 1956</u>		REGISTRAR'S SIGNATURE <u>T.E. Harris</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. Burke Dudley, Dundalk, Md.</u> ADDRESS			



11636 **CERTIFICATE OF DEATH**Reg. Dist. No. 30

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY <u>Baltimore</u> (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place) <u>46 days</u>		CITY <u>Baltimore</u> (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Baltimore</u>				TOWN <u>Baltimore</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove State Hospital Baltimore, 28, Maryland</u>				STREET ADDRESS <u>1802 Eutaw Place</u>			
3. NAME OF DECEASED (Type or Print) <u>Ferdinand Jelinek</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>12 5 19 55</u>			
S. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>3/11/1884</u>	9. AGE last birthday <u>71</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>		11. BIRTHPLACE (State or foreign country) <u>Unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Unknown</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Spring Grove Hospital Records Baltimore, 28, Maryland</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) - <u>Pulmonary thrombosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) - <u>Inanition and dehydration</u>						<u>2 weeks</u>	
(C) - <u>Senile brain disease</u>						<u>years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>12/5</u>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10/19</u> 19 <u>55</u> , to <u>12/5</u> 19 <u>55</u> , that I last saw the deceased alive on <u>12/5</u> 19 <u>55</u> , and that death occurred at <u>4:15</u> P. from the causes and on the date stated above. SIGNATURE <u>Stella Wachser</u> M.D. <u>Spring Grove State Hospital,</u> DATE SIGNED <u>12/6/55</u> ADDRESS (Street, city, town, state) (State)							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>12-9-55</u>		NAME OF CEMETERY OR CREMATORY <u>OAK HILL</u>		LOCATION (City, town, or county) (State) <u>BALTIMORE MD</u>	
24. REC'D BY REGISTRAR <u>DATE</u>		REGISTRAR'S SIGNATURE <u>P. E. Ranso</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Crook Funeral Home</u>		ADDRESS <u>ashland ave</u>	

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24** hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72** hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M



18-1000000

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11637 CERTIFICATE OF DEATH

Reg. Dist. No. 1

1. PLACE OF DEATH:

COUNTY BALTIMORE

MARYLAND

CITY (If outside corporate limits, write RURAL
OR and give nearest town)
TOWN FORT HOWARDLENGTH OF STAY
(in this place)
112 DAYSHOSPITAL OR
INSTITUTION OR
STREET ADDRESSVETERANS ADMINISTRATION HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE MARYLAND COUNTYCITY (If outside corporate limits, write RURAL and give nearest town)
OR
TOWN BALTIMORE

STREET ADDRESS (If rural give location)

2539 N. Howard Street3. NAME OF
DECEASED:
(Type or Print)(First) ARTHUR(Middle) J.(Last) JOHNSON

4. DATE (Month) (Day) (Year)

OF DEATH: December 23, 1955

5. SEX:

MALE6. COLOR OR
RACE: COLORED7. SINGLE, MARRIED,
WIDOWED, DIVORCED.
(Specify): MARRIED

8. DATE OF BIRTH:

December 15, 18969. AGE last birthday: 59 yrs.IF UNDER 1 YEAR
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life,
even if retired): CHAUFFEUR10B. KIND OF BUSINESS
OR INDUSTRY:
City of Baltimore11. BIRTHPLACE (State or foreign country):
Lauraville, Maryland12. CITIZEN OF WHAT
COUNTRY?
U.S.A.

13. FATHER'S NAME:

Frank Johnson

14. MOTHER'S MAIDEN NAME:

Jane Owens15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unk.) (If Yes, give war or dates
of service) Yes WW-116. SOCIAL SECURITY NO.
Unknown

17. INFORMANT & ADDRESS:

Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE

(A) CARCINOMA OF PROSTATE WITH METASTASES TO

ANTECEDENT CAUSE (B)

XIPHOPH LIVER AND LUMBAR VERTEBRAEDISEASES OR CONDITIONS, IF ANY,
GIVING RISE TO THE ABOVE CAUSE
STATING UNDERLYING CAUSE LAST.(B)
DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.INTERVAL BETWEEN
ONSET AND DEATH18 Months

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)21B. PLACE (Home, farm, factory,
OF INJURY street, office bldg., etc.)21C. WHERE DID (City or town) (County) (State)
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY21E. INJURY OCCURRED
While ☐ Not while ☐
at work at work

21F. HOW DID INJURY OCCUR?

2. I hereby certify that I attended the deceased from Sept. 2, 1955, to Dec. 23, 1955, and that death occurred at 1:55 PM, from the causes and on the date stated above.

SIGNATURE

Donald D. Mark, M. D.

ADDRESS

M. D. VAH, FORT HOWARD, MARYLAND 12-24-55

DATE SIGNED

23. BURIAL, CREMATION,
REMOVAL (SPECIFY)DATE THEREOF
12/28/55NAME OF CEMETERY OR CREMATORY
Balto. NationalLOCATION (City, town, or county) (State)
Cemetery Baltimore, MarylandDATE REC'D BY LOCAL
REGISTRAR 12-27-55

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Charles R. Law Funeral Home, 802-02 Madison Ave. Balt. Md.

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



11636

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

11638

Reg. Dist. No. 30

1. PLACE OF DEATH- COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY _____	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Catonsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove State Hospital</u>		STREET ADDRESS <u>227 N. Fulton Avenue</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Harold</u> (Middle) <u>Ashby</u> (Last) <u>Johnson</u>	4. DATE OF DEATH (Month) <u>December</u> (Day) <u>26</u> (Year) <u>1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Married</u>	8. DATE OF BIRTH <u>4-4-1905</u>
9. AGE last birthday <u>50</u> yrs.		10. AGE last birthday If under 1 year: Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	
11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Bedford C. Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Edna ?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT AND ADDRESS <u>Records Spring Grove State Hospital</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) _____

Antecedent cause(s) (b) _____

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c) _____

Cerebral Hemorrhage

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☒ No ☐ (STATE)21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, or office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☒ Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE

DATE SIGNED

Dr. McKaffee *Dec 31/55* *Reimerview* *1010 Leed Ave* *12-28-55*

23. BURIAL, CREMATION REMOVAL (Specify) DATE THEREOF NAME OF CEMETERY OR CREMATORY LOCATION (City, town, or county) (State)

Burial *Dec 31/55* *Reimerview* *Reimerview West. Vir.*

DATE REC'D BY LOCAL REGISTRY'S SIGNATURE 24. FUNERAL DIRECTOR ADDRESS

Dec 30, 1955 *V. E. Harry* *Philip Harry Sons Orleans*

MARGIN RESERVED FOR INDEXING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 6

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 30

11639

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTO CT.</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>BALTO.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>52 CATONSVILLE</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		<u>52</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>315 SHADEY NOOK AVE</u>				STREET ADDRESS (If rural give location) <u>315 SHADEY NOOK AVE</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>MARGARET C JOHNSON</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>12/10/55</u> 19 <u>55</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>MAR. 7, 1880</u>	9. AGE last birthday <u>75</u> yrs.	10. IF UNDER 1 YEAR Months		11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wm CASHAMER</u>				14. MOTHER'S MAIDEN NAME <u>VIESMAN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>1-34-34321</u>		17. INFORMANT & ADDRESS <u>W. Ardene Johnson</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18 months	
153X IMMEDIATE CAUSE (A) <u>Carcinoma of Transverse Colon</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>& General Metastases</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>1/13/55</u>		19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma of Transverse Colon</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>9/22</u> , 19 <u>49</u> , to <u>2/10</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>2/9</u> , 19 <u>55</u> , and that death occurred at <u>3:10 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Eliot W. Johnson M.D.</u>				DATE SIGNED <u>12/13/55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>12/13/55</u>		NAME OF CEMETERY OR CREMATORY <u>LOUDON PARK</u>		LOCATION (City, town, or county) (State) <u>BALTO MD</u>	
24. REC'D BY REGISTRAR <u>12/12/55</u>		REGISTRAR'S SIGNATURE <u>V.E. Harris</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Malcolm + Son</u>		ADDRESS <u>28</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 14 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

BUREAU V. 3.

DEC 14 1955

RECEIVED

DEC 22 1955

MARYLAND STATE DEPARTMENT OF HEALTH

11638

2411 N. Charles Street, Baltimore

11640

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Penn.</u> COUNTY <u>Dauphin.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Catonsville</u> LENGTH OF STAY (in this place) <u>27 da.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Harrisburg</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Home in Penn.</u>		STREET ADDRESS (If rural, give location) <u>4816 Orchard St.</u>	
3. NAME OF DECEASED (Type or Print) <u>Harwood</u> (First) <u>M</u> (Middle) <u>Jones</u> (Last)		4. DATE OF DEATH (Month) <u>12</u> (Day) <u>13</u> (Year) <u>1955</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH <u>June 23, 1889</u>
9. AGE last birthday <u>66</u> yrs.		10. If under 1 year: Months <u>12</u> Days <u>13</u> Hours <u>13</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Superintendent</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Steel Mill.</u>	
11. BIRTHPLACE (State or foreign country) <u>Oak Park, Illinois.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>William Thayer Jones.</u>		14. MOTHER'S MAIDEN NAME <u>Marion Marsh.</u>	
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>172-01-8045</u>	
17. INFORMANT AND ADDRESS <u>W. Benjamin Jones; Mechanical Eng. Pa. R.D.</u>			

15. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) <u>Carcinoma of Bladder</u>		<u>13m.</u>	
Antecedent cause(s) (b) <u>Metastatic Ca of Lung</u>		<u>62m.</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Nov 16, 1955, to Dec 13, 1955, that I last saw the deceased alive on 12-13, 1955, and that death occurred at 8:45 p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Cremation</u>		<u>Dec 15, 1955</u>	<u>Henninger Crematory</u>	<u>Reading, Penna.</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE	FUNERAL DIRECTOR'S ADDRESS		
<u>12/14/55</u>		<u>T. E. Harry</u>	<u>J. Jacob Hartman, New Freedom, Pa.</u>		

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

F B I BUREAU V. S.

DEC 15 1975

RECEIVED

11641

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Baltimore		MARYLAND		STATE Md.		COUNTY Harford	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWNS Towson		LENGTH OF STAY (in this place) 6 yrs.		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Highland			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Presbyterian Home				STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED: (First) (Middle) (Last) Hattie Jones				4. DATE OF DEATH: (Month) (Day) (Year) Dec. 22, 19 55			
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): WIDOW	8. DATE OF BIRTH: June 10, 1875	9. AGE last birthday: 80 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Teacher-Ret. School				10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): Harford Co., Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME: William H. Wilson			
14. MOTHER'S MAIDEN NAME: Pauline Whiteford				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No			
16. SOCIAL SECURITY No.: None				17. INFORMANT & ADDRESS: Mrs. Elliott, Supt. Presbyterian Home			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
420.1 Immediate cause (a) Heart disease, vascular, coronary occlusion							12/24/55
Antecedent cause(s) (b) Cardis-vascular disease with Hypertension							10 yrs ±
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) Atherosclerosis							Unknown
II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION:							20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Not while M. work <input type="checkbox"/> at work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from June, 1952, to Dec. 24, 1955, that I last saw the deceased alive on Dec. 24, 1955, and that death occurred at 9 A.M., from the causes and on the date stated above.							
SIGNATURE Rollin C. Hudson M.D.				ADDRESS Towson 4 Md		DATE SIGNED 12/24/55	
23. BURIAL, CREMATION REMOVAL (Specify): Burial		DATE THEREOF Dec. 27, 1955		NAME OF CEMETERY OR CREMATORY Highland Presbyterian		LOCATION (City, town, or county) (State) Highland, Md.	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR John O. Mitchell & Sons 1900 Eutaw Place			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Ma</u>	COUNTY <u>Balto</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Stoneleigh</u>	LENGTH OF STAY (in this place) <u>15 yrs</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Stoneleigh</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>7101 York Rd</u>		STREET ADDRESS (If rural give location) <u>7101 York Rd</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <u>LLEWELYN</u>	(Middle) <u>E</u>	(Last) <u>JONES SR</u>	(Month) <u>Dec</u> (Day) <u>20</u> (Year) <u>1955</u>
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>MARRIED</u>	8. DATE OF BIRTH: <u>Mar. 8 1875</u>
		9. AGE last birthday: <u>80</u> yrs.	10. IF UNDER 1 YEAR: <u>0</u> Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min.
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: <u>OWNER</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>WIRE & IRON</u>	11. BIRTHPLACE (State or foreign country): <u>Mass</u>
13. FATHER'S NAME: <u>Elijah Jones</u>		14. MOTHER'S MAIDEN NAME: <u>Caroline Edler</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) <u>No</u>		16. SOCIAL SECURITY No.: <u>212-01-4574</u>	
(If Yes, give war or dates of service)		17. INFORMANT & ADDRESS: <u>Mrs. L.E. Jones Sr. Same</u>	
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			Interval Between Onset And Death
Immediate cause (a) <u>Cardiac Decompensation</u>			<u>3 months</u>
Antecedent causes (s) (b) <u>Arteriosclerotic Cardio-Renal Vascular Disease</u>			<u>10 years</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c) <u>Mild Diabetes Mellitus</u>			<u>8 yrs</u>
11. OTHER SIGNIFICANT CONDITIONS			
Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION: <u>0</u>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)	
SUICIDE		(CITY OR TOWN)	
HOMICIDE		(COUNTY)	
(STATE)			
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED	
m.		While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>June 1948</u> , to <u>December 20, 1955</u> , that I last saw the deceased alive on <u>December 9, 1955</u> , and that death occurred at <u>5:20 PM</u> , from the causes and on the date stated above.			
SIGNATURE		DATE SIGNED	
<u>Charles F. O'Donnell MD</u>		<u>12/20/55</u>	
ADDRESS			
<u>7501 York Rd Towson 4 Md</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)		NAME OF CEMETERY OR CREMATORY	
<u>Burial</u>		<u>Gowans Presbyterian</u>	
DATE THEREOF		LOCATION (City, town, or county) (State)	
<u>Dec 22 1955</u>		<u>Balto., Md</u>	
DATE REC'D BY LOCAL REGISTRAR		24. FUNERAL DIRECTOR, ADDRESS	
<u>12-21-55</u>		<u>Henry W. Jenkins 4905 York Rd</u>	
REGISTRAR'S SIGNATURE			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11643 **CERTIFICATE OF DEATH**

11641

Reg. Dist. No. 45

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Balto</u>		MARYLAND		STATE <u>md.</u>		COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Essex</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Essex</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>531 Eastern Blvd.</u>				STREET ADDRESS (If rural give location) <u>531 Eastern Blvd. 21 md.</u>			
3. NAME OF DECEASED (Type or Print) <u>Samantha</u> (First) <u>Jones</u> (Middle) (Last)				4. DATE OF DEATH (Month) <u>Dec.</u> (Day) <u>26</u> (Year) <u>1955</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>March 2-1875</u>	9. AGE last birthday <u>80</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Tenn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jessie Harris Jones</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no.</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Dora Moore 918 Renfrew St.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
4. IMMEDIATE CAUSE (A) <u>Hypostatic Pneumonia</u>				INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>years</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hepatic Arteriosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 3, 1955</u> to <u>Dec 26, 1955</u> , that I last saw the deceased alive on <u>Dec 23, 1955</u> , and that death occurred at <u>12:25</u> P.M. from the causes and on the date stated above.							
SIGNATURE <u>Dr. J. J. Tyden</u> M.D.				ADDRESS (Street, city, town, state) DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u>		DATE THEREOF <u>12-28-55</u>		NAME OF CEMETERY OR CANADARY <u>Bowling Spring</u>		LOCATION (City, town, or county) (State) <u>White Co. Tenn.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Earl Hurrey</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J. B. Bingham</u>		ADDRESS <u>1407 Eastern Ave</u>	
DATE <u>12/27/55</u>							

11642

MARYLAND STATE DEPARTMENT OF HEALTH

11644

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 45

1. PLACE OF DEATH- COUNTY <u>BALTO</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MD.</u> COUNTY <u>BALTO</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> TOWN <u>MIDDLEBOROUGH</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> TOWN <u>MIDDLEBOROUGH</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>MIDDLEBOROUGH RD.</u>		STREET ADDRESS (If rural, give location) <u>MIDDLEBOROUGH RD</u>	
3. NAME OF DECEASED (Type or Print) <u>ANNA</u>	(First) (Middle) (Last) <u>KANIS</u>	4. DATE OF DEATH <u>12/27/1955</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>M.</u>	8. DATE OF BIRTH <u>JULY 2-1911</u>
9. AGE last birthday <u>44</u> yrs.		10. AGE last birthday If under 1 year If under 24 hrs. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>?</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>-</u>		16. SOCIAL SECURITY No. <u>-</u>	
17. INFORMANT AND ADDRESS <u>CASIMIR KANIS</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(a) Immediate cause <u>Gunshot wound</u>		<u>60 Sec</u>	
(b) Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last			
(c) OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> accident <input type="checkbox"/> suicide <input checked="" type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> .			
SIGNATURE <u>Jack Collins M.D.</u>		DATE SIGNED <u>12-29-55</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>BALTO</u>		DATE THEREOF <u>12/30/55</u>	
NAME OF CEMETERY OR CREMATORY <u>SACRED HEART</u>		LOCATION (City, town, or county) <u>BALTO</u>	
24. FUNERAL DIRECTOR <u>John J. Connelly</u>		ADDRESS <u>Essex md</u>	
DATE REC'D BY LOCAL REG. <u>12/3/55</u>		REGISTRAR'S SIGNATURE <u>Edith Hurley</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

U.S. AIR FORCE

9

11645 CERTIFICATE OF DEATH

Reg. Dist. No.

1. NAME OF DECEASED
(Type or Print)

Mrs IRENE M. KARUS

2. DATE
OF
DEATH

Dec. 9, 1955

3. PLACE OF DEATH:

A. Baltimore City, Maryland Baltimore Co.

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

MD

ALLEGANY COUNTY

C. CITY OR TOWN

CUMBERLAND

D. STREET ADDRESS (If rural, give location)

116 KARUS AVE.

c. Length of stay in Baltimore

11

Mos
Days

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Wid.

8. DATE OF BIRTH

Aug. 22, 1878

9. AGE (In years
last birthday)

77

10. Under 1 Year
Months: Days:11. Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

HOUSEWIFE

10B. KIND OF BUSINESS OR
INDUSTRY

—

11. BIRTHPLACE (State or foreign country)

PENNSYLVANIA

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

JOE GARLAND

14. MOTHER'S MAIDEN NAME

Eileen BARNEY GARLAND

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, on or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Son DR. I. KARUS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) Mesenteric Thrombosis, suspected ? 6 hrs.

DUE TO

490X ANTECEDENT CAUSES

(B) Pneumonia, lobar 2 days

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(C) Hypertensive Arteriosclerotic Cardio-vascular disease 4 yrs.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

CEREBRAL THROMBOSIS Rt.

1 yr.

IF OPERATION WAS RELATED TO
CAUSE OF DEATH, ENTER IN
PART I OR PART II

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20. AUTOPSY?

YES ☐ NO ☒

OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I certify that (I) (this hospital) attended the deceased from January 8, 1955 to Dec. 9, 1955, that (I) (we) last saw the deceased alive on Dec. 8, 1955, and that death occurred at 7:05 P. M., from the causes and on the date stated above.

23A. SIGNATURE

Wm. Carl Ebeling M.D.

23B. ADDRESS

University Hosp. Balto

23C. DATE SIGNED

Dec. 9, 1955

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

12-12-55

24C. NAME OF CEMETERY OR CREMATORY

Mt. Forest Cem.

24D. LOCATION (City, town, or county)

Cumberland Md

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

Dec. 9, 1955

REGISTRAR'S SIGNATURE

Mabel C. Gray

25. FUNERAL DIRECTOR

Howard H. Hubbard

ADDRESS

THIS IS A PERMANENT RECORD. PLEASE TYPE OR WITH PERMANENT BLACK OR BLUE-BLACK INK. DO NOT USE A BALL POINT PEN.

Every item of information be carefully supplied. Physicians: please write the causes of death clearly and let HIS CERTIFICATE MUST BE WITH THE BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11644

11646

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		STATE <u>MARYLAND</u>		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR	
TOWN <u>Fort Howard</u>		<u>51 Days</u>		TOWN <u>Baltimore</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location) <u>1641 Waverly Way</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>CHARLES</u>		(Middle) <u>HENRY</u>		(Last) <u>KECK</u>		(Month) (Day) (Year)	
						<u>December 20 1955</u>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>7-19-93</u>	<u>62</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Army Officer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Hawk, Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13. FATHER'S NAME <u>Edmund Keck</u>				14. MOTHER'S MAIDEN NAME <u>Clara Bierhop</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>8-22-17 to 6-30-53</u>			16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>		
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						<u>UNKNOWN</u>	
IMMEDIATE CAUSE (A) <u>ADENOCARCINOMA KIDNEY, LEFT, WITH METASTASIS</u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct. 31, 1955</u> , to <u>Dec. 20, 1955</u> , that I last saw the deceased <u>at home</u> , and that death occurred at <u>8:00 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>F. S. Dickey</u>				ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>Francis G. Dickey, M.D., Chief Medical Service VAH, FORT HOWARD, MARYLAND</u>						<u>12-20-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Removal</u>		<u>12/20/55</u>		<u>St. Joseph Cemetery</u>		<u>Newark, Ohio</u>	
24. REG'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>DEC 21 1955</u>		<u>Dawson L. Farley</u>		<u>Wm. Tickner & Sons, Inc., North & Panna Ave.</u>		<u>Baltimore, Md.</u>	

BUREAU V. S.

DEC 22 1955



11647 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

COUNTY Baltimore MARYLAND
 CITY (If outside corporate limits, write RURAL and give nearest town)
 OR TOWN Hereford (in this place)
 HOSPITAL OR INSTITUTION OR STREET ADDRESS York Road

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Baltimore
 CITY (If outside corporate limits, write RURAL and give nearest town)
 OR TOWN Hereford
 STREET ADDRESS (If rural give location)
York Road

3. NAME OF DECEASED:

(First) Minnie (Middle) (Last)
 (Type or Print) Amelia Stoll Keil

4. DATE OF DEATH: Dec. 14 19 55

5. SEX:

Female

6. COLOR OR RACE:

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

Married

8. DATE OF BIRTH:

2/14/184

9. AGE last birthday:

71

IF UNDER 1 YEAR IF UNDER 24 HRS.
 Months Days Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired):

At home

10b. KIND OF BUSINESS OR INDUSTRY:

Baltimore, Md

12. CITIZEN OF WHAT COUNTRY?

U. S.

13. FATHER'S NAME:

Christian Stoll

14. MOTHER'S MAIDEN NAME:

Anna Graf

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

Y

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

Mr. Charles A. Keil, York Rd, Hereford, Md

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Cerebral hemorrhage
DUE TO

Antecedent causes (s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b)

hypertension
DUE TO

(c)

Generalized arterio-sclerosis

Interval Between Onset And Death

4 days

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

0

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1945, to Dec. 14, 1955, that I last saw the deceased alive on 12/12, 1955, and that death occurred at 6:30 p.m. from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county) (State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

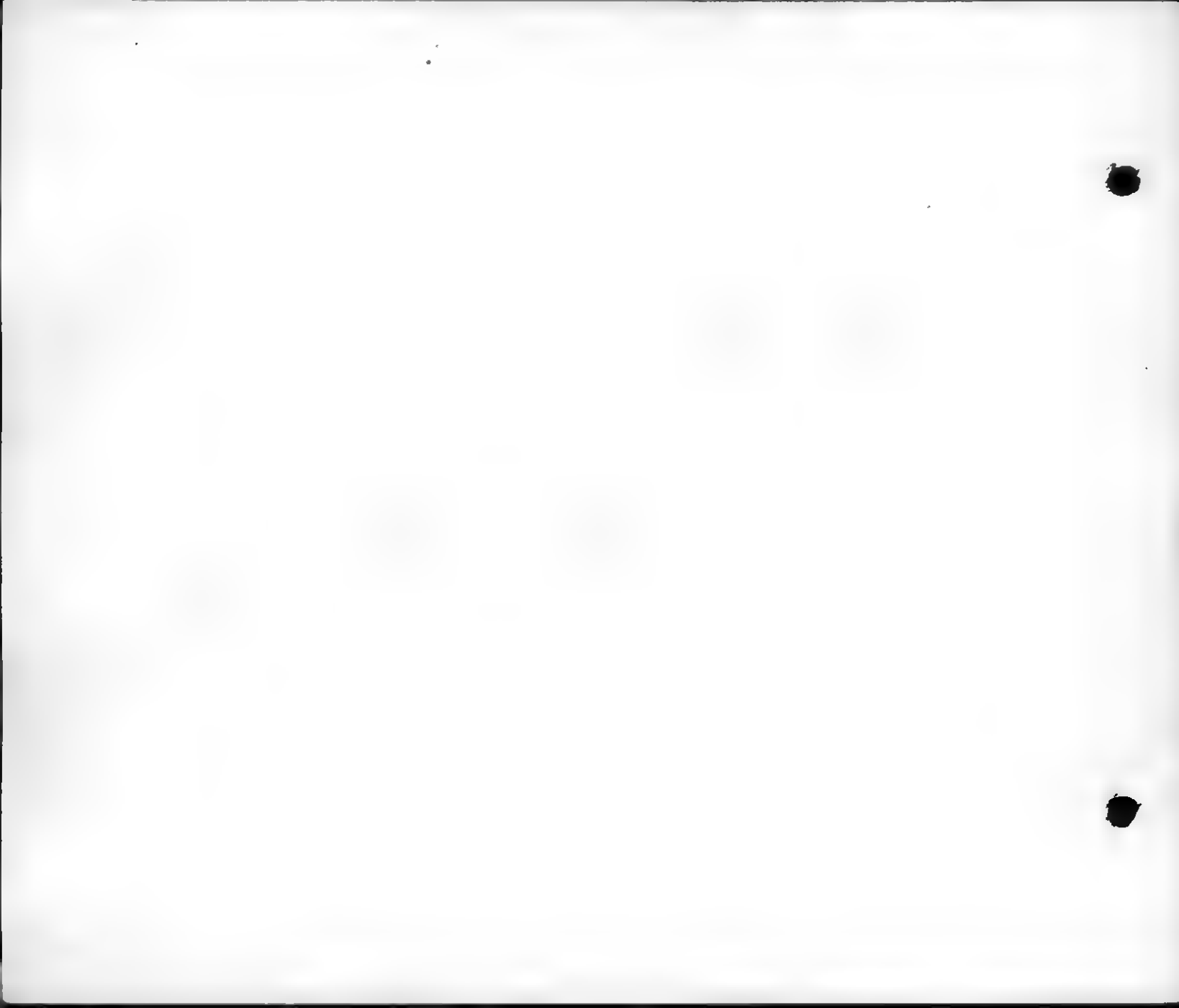
ADDRESS

Dec 14, 1955 A. A. HedrickJ. Ruck, 5305 Harford Rd, Balto 14, Md

MARGIN RESERVE FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.



11648

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTO.</u>		MARYLAND		STATE <u>S</u> COUNTY			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>SPARROWS POINT</u>		<u>31 YRS</u>		TOWN <u>SPRING</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1007 H ST.</u>				STREET ADDRESS <u>#1</u> (If rural give location) <u>AS</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>MIRIA</u> (Middle) <u>ELLA</u> (Last) <u>KELLY</u>				(Month) <u>12-29-</u> (Day) <u>1955</u> (Year)			
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>SEPT. 9, 1884</u>	9. AGE last birthday <u>71</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>PENNA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>HARRY SOLES</u>				14. MOTHER'S MAIDEN NAME <u>CAROLYN HOFFMAN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give rank.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NOTE</u>		17. INFORMANT & ADDRESS <u>JAMES A. KELLY - SAME</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
4. IMMEDIATE CAUSE (A) <u>Arteriosclerosis of Ht. & Lungs</u>				INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis</u>				<u>10 yrs.</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input checked="" type="checkbox"/> work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept. 1954</u> , to <u>Dec. 29</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Dec. 29</u> , 19 <u>55</u> , and that death occurred at <u>7 P.</u> M., from the causes and on the date stated above.							
SIGNATURE <u>J. A. Jones</u>				DATE SIGNED <u>12/30/55</u>			
ADDRESS (Street, city, town, state) <u>530 D St. Balto. Md.</u>							
23. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		DATE THEREOF <u>1/3/56</u>		NAME OF CEMETERY OR CREMATORY <u>oak lawn</u>		LOCATION (City, town, or county) <u>BALTO. CO, MD.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Lawrence P. Varber</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur P. Pugh</u>		ADDRESS <u>1007 H St. Balto. Md.</u>	
DATE <u>1/3/55</u>							

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been examined by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

BUREAU V. S.

JAN 5 1956

RECEIVED

11649

11647

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

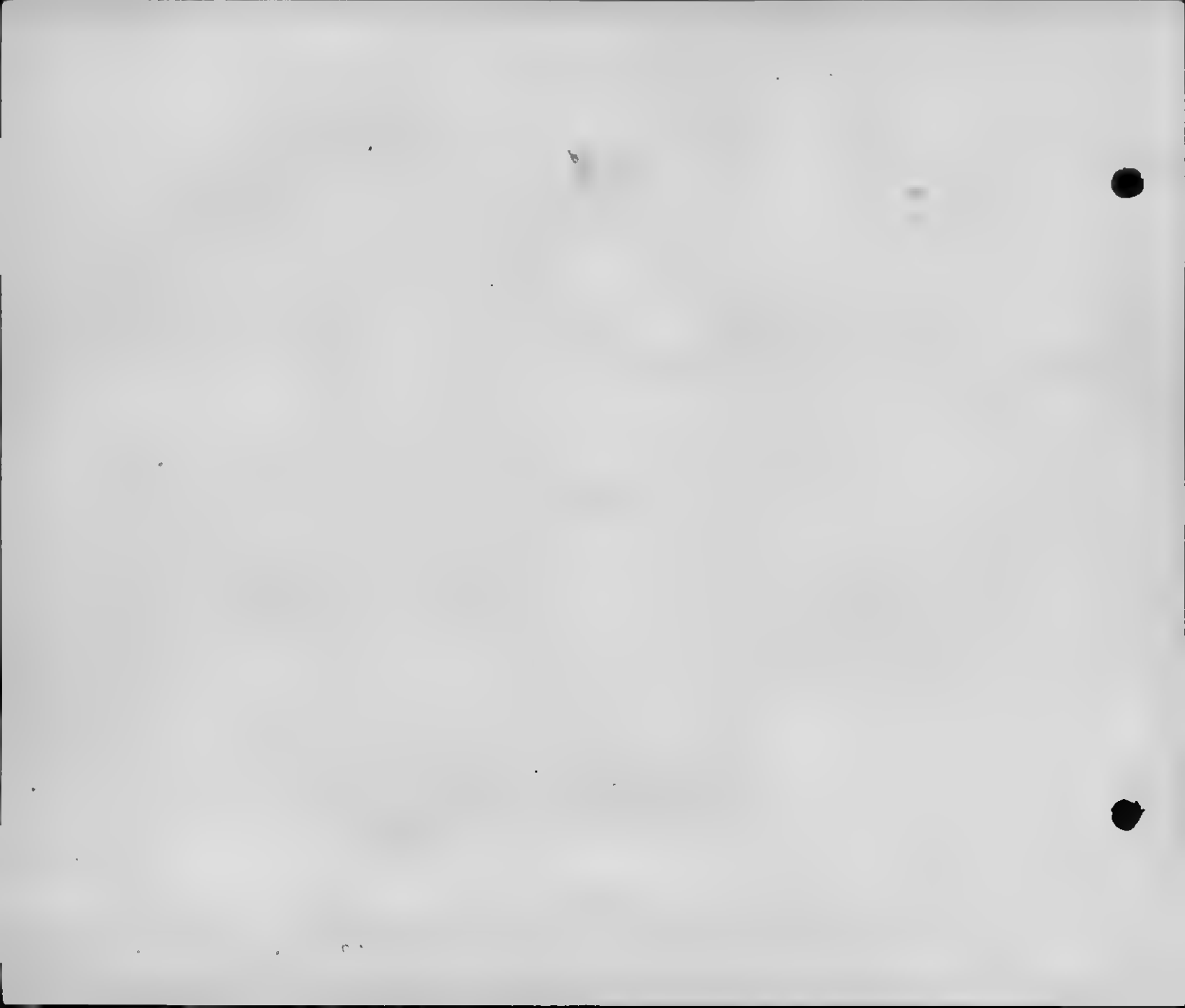
No. 7

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY	Baltimore	MARYLAND	STATE	Md.	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town)	TOWN	SPARROWS POINT	CITY (If outside corporate limits write RURAL and give nearest town)	OR	TOWN
HOSPITAL OR INSTITUTION OR STREET ADDRESS			STREET ADDRESS		
Old Bay Shore Park			2735 Harlem Avenue		
3. NAME OF DECEASED:			4. DATE OF DEATH		
(First)	(Middle)	(Last)	(Month)	(Day)	(Year)
PAUL	PEYTON	KENNEY	12	18	19 55
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:		
Male	Colored	Married	11-4-1921		
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):			10b. KIND OF BUSINESS OR INDUSTRY:		
Janitor			Union Hall		
13. FATHER'S NAME:			14. MOTHER'S MAIDEN NAME:		
William Kenney			Helen Dixon		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)			16. SOCIAL SECURITY No.:		
Yes			II		
17. INFORMANT & ADDRESS:			Carrie Kenney 2735 Harlem Ave.		

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH		
Immediate cause			(a) Exposure					
Antecedent cause(s)			(b) Diseases or conditions, if any, giving rise to the above cause					
stating underlying cause last			(c)					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.								
19a. DATE OF OPERATION:			19b. MAJOR FINDING OF OPERATION:			20. AUTOPSY?		
						Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY			21c. (City or town) (County) (State)		
			Park			Sparrows Point Baltimore Maryland		
21d. TIME (Month) (Day) (Year) (Hour)			21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>			21f. HOW DID INJURY OCCUR?		
OF INJURY 12/18/55 3 PM.						Found dead in park, exposed to weather.		
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
SIGNATURE			M. D.			DATE SIGNED		
William Upchurch						12/19/55		
23. BURIAL, CREMATION, REMOVAL (Specify):			NAME OF CEMETERY OR CREMATORY			LOCATION (City, town, or county) (State)		
Burial			Baltimore National			Baltimore, Maryland		
DATE REC'D BY LOCAL REG.			REGISTRAR'S SIGNATURE			24. FUNERAL DIRECTOR ADDRESS		
12/20/55			[Signature]			802-04 Madison Ave. Charles R. Law		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



11650

CERTIFICATE OF DEATH

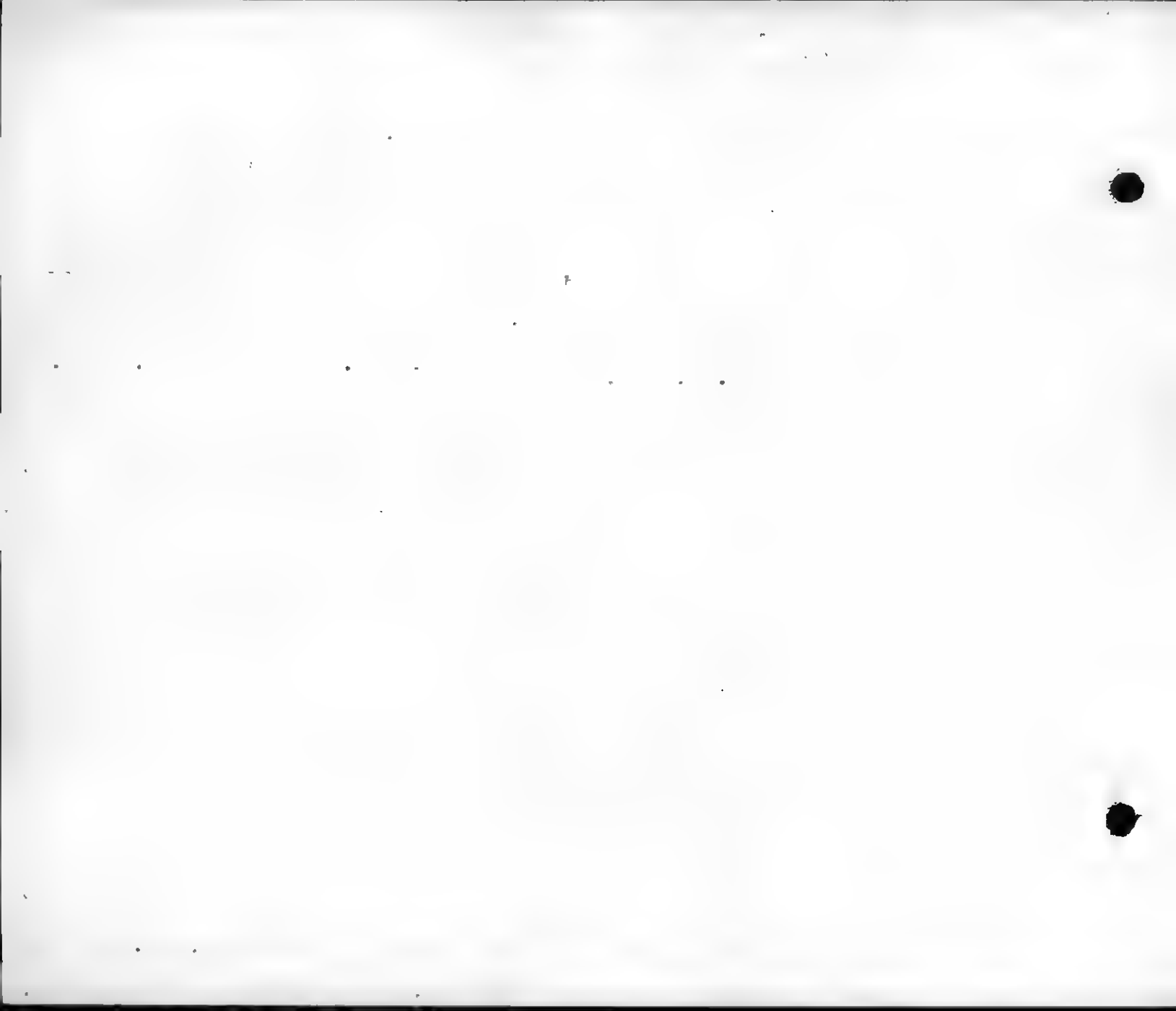
Reg. Dist. No. 35

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		LENGTH OF STAY (in this place) --		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Towson</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Armacost Nursing Home</u>				STREET ADDRESS (If rural give location) <u>532 Stevenson Lane</u>			
3. NAME OF DECEASED:				4. DATE (Month) (Day) (Year)			
(First) <u>George</u>		(Middle) <u>Kirtley</u>		(Last) <u>Kirtley</u>		DATE: <u>Dec. 20, 1955</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>May 4, 1874</u>	9. AGE last birthday: <u>81</u> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.	IF UNDER 24 HRS.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>--</u>			10B. KIND OF BUSINESS OR INDUSTRY: <u>A. T. & T.</u>		11. BIRTHPLACE (State or foreign country): <u>Phila., Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13. FATHER'S NAME: <u>St. Clair David Kirtley</u>				14. MOTHER'S MAIDEN NAME: <u>Mary E. Simpson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		15. SOCIAL SECURITY NO. <u>212-01-5007</u>		17. INFORMANT & ADDRESS: <u>Mrs. Pauline K. McPherson-1218 Southview Rd.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE		(A) <u>Bronchial Pneumonia</u>				<u>4 Days</u>	
ANTECEDENT CAUSE (S)		(B) <u>Generalized Hypertension</u>					
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(C) <u>Cardio Renal Vascular Disease</u>				<u>20 yrs</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct 9, 1946</u> to <u>Dec 20, 1955</u> , that I last saw the deceased alive on <u>Dec 20, 1955</u> , and that death occurred at <u>10:40 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Charles F. Donnell</u>				ADDRESS <u>M.D. 7501 York Rd. Towson 4th Md.</u>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>12/22/55</u>		<u>New Cathedral Cemetery</u>		<u>Baltimore, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>12-31-55</u>		<u>John A. Moran</u>		<u>John A. Moran-3000 E. Baltimore St.</u>			

MARGIN RESERVED FOR BINDING

VS. A15 — 10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

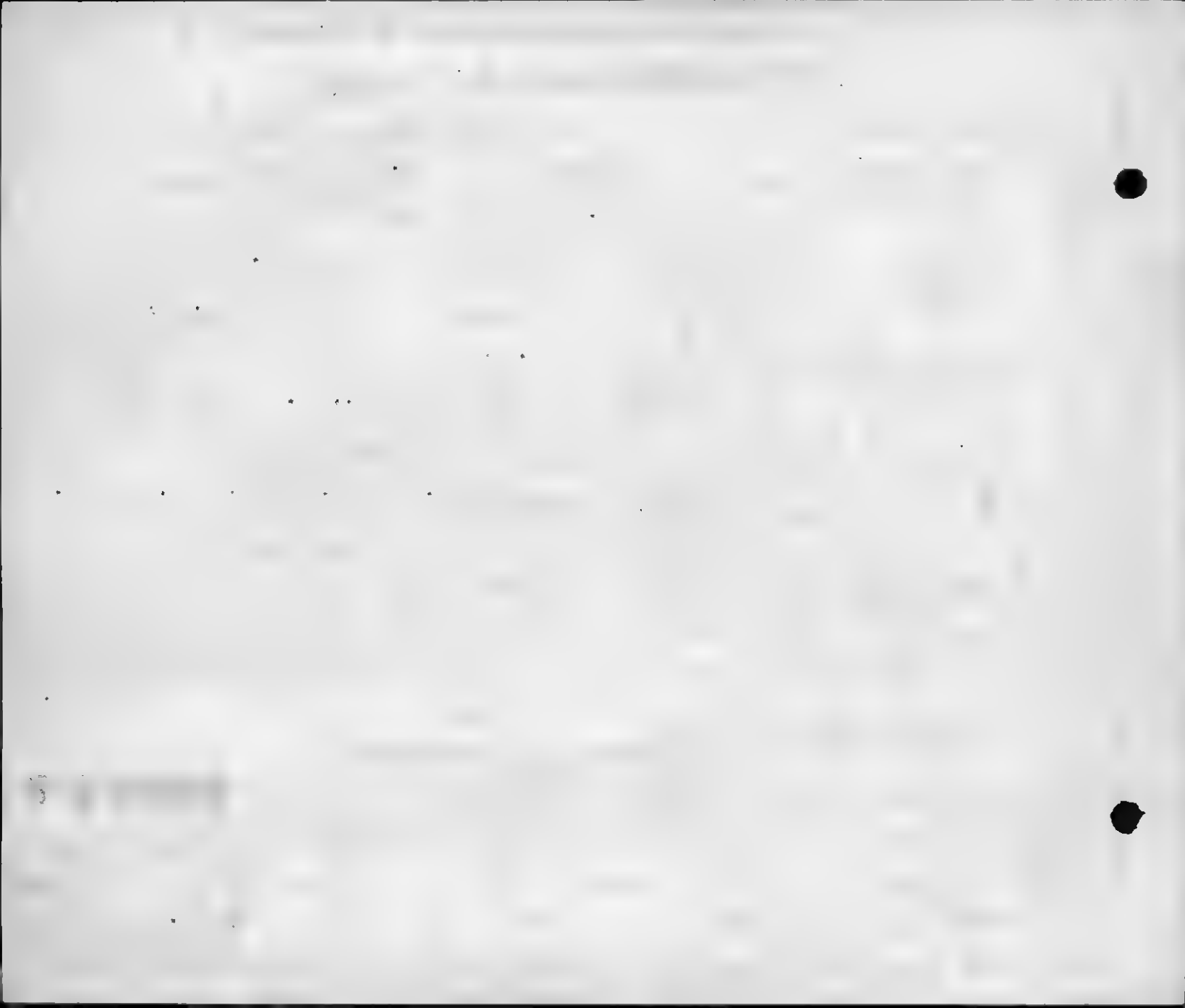
11651

CERTIFICATE OF DEATH

11649

Reg. Dist. No. 45

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		STATE <u>Pa.</u>		COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Middle River</u>		LENGTH OF STAY (in this place) <u>1 mo.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethlehem</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Ivy Hall Nursing Home</u>		STREET ADDRESS (If rural give location) <u>523 First Ave.</u>					
3. NAME OF DECEASED (Type or Print) <u>MARY ADELINE KLECKNER</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Dec. 22, 1955</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>		8. DATE OF BIRTH <u>Sept. 8, 1869</u>	
9. AGE last birthday <u>86</u> yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (State or foreign country) <u>Northampton Co., Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Francis Henry Leidich</u>				14. MOTHER'S MAIDEN NAME <u>Isadora Adeline Weitknecht</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Mrs. David C. Nowack, 15 E. Elm Ave.</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Haemorrhage from G.I. tract</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 mos</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Carcinoma of Colon</u>						<u>3 mos</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Cardiac Failure</u>						<u>4 weeks</u>	
19a. DATE OF OPERATION <u>1</u>		19b. MAJOR FINDINGS OF OPERATION <u>Inoperable carcinoma of colon</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec 3, 1955</u> , to <u>Dec 22, 1955</u> , that I last saw the deceased alive on <u>Dec 17, 1955</u> , and that death occurred at <u>4 P.</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Harvey L. Fuller</u>				ADDRESS (Street, city, town, state) <u>Ridge Rd, Baltimore 6</u>		DATE SIGNED <u>Dec 23/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>burial</u>		DATE THEREOF <u>12/27/55</u>		NAME OF CEMETERY OR CREMATORY <u>Niesky Hill Cemetery</u>		LOCATION (City, town, or county) (State) <u>Bethlehem, Pa.</u>	
24. REC'D BY REGISTRAR <u>Dec 27, 1955</u>		REGISTRAR'S SIGNATURE <u>Mrs Edith Hurleys</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Larsen Funeral Home</u>		ADDRESS <u>401 Belair Road</u>	



11652

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY Baltimore MARYLAND			STATE Maryland COUNTY		
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Fort Howard			CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore		
HOSPITAL OR INSTITUTION OR STREET ADDRESS Veterans Administration Hospital			STREET ADDRESS (If rural give location) 631 N. Carey Street		
3. NAME OF DECEASED: (Type or Print) CLARENCE A. KNOX			4. DATE (Month) (Day) (Year) OF DEATH: December 30 1955		
5. SEX: Male	6. COLOR OR RACE: Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single	8. DATE OF BIRTH: 11/7/32		
9. AGE last birthday: 23 yrs.			10. BIRTHPLACE (State or foreign country): Chicago, Ill.		
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME: Sidney T. Knox			14. MOTHER'S MAIDEN NAME: Bertha Mounton		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) Yes PL-28			16. SOCIAL SECURITY NO. 216-30-8896		
17. INFORMANT & ADDRESS: Clin. Rec. Vet. Adm. Hosp., Ft. Howard, Maryland					

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE 59ax (A) MASSIVE HEMORRHAGE OF LEFT CEREBRAL DUE TO XHEMISPHERE		SUDDEN
ANTECEDENT CAUSE (S) (B) DUE TO: ACUTE VASCULAR NEPHRITIS		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION: 2	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY VA M.	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21F. HOW DID INJURY OCCUR?

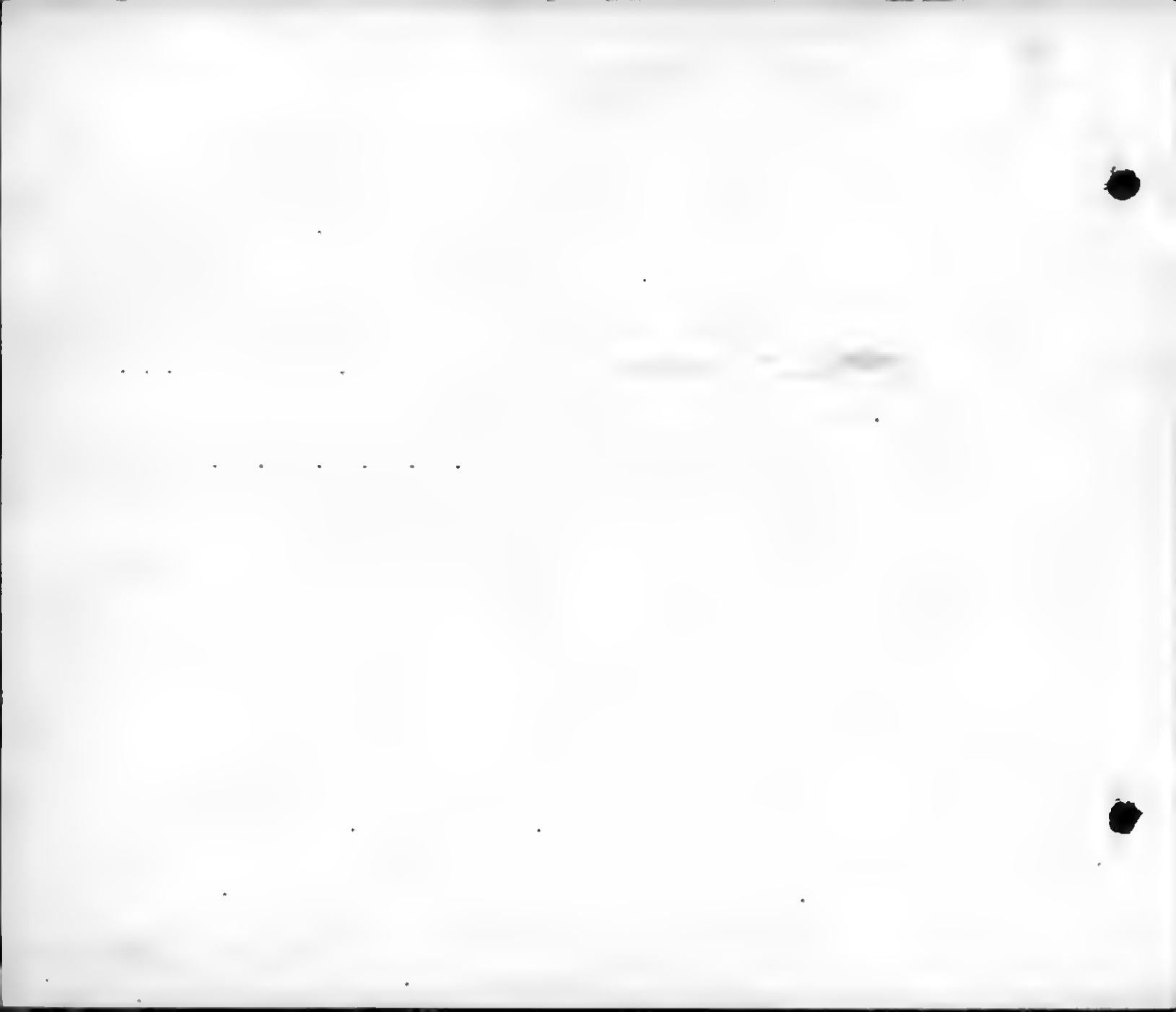
22. I hereby certify that I attended the deceased from **Nov. 28, 1955**, to **Dec. 30, 1955**, and that death occurred at **9:10 P M.** from the causes and on the date stated above.

SIGNATURE **Donald D. Mark, M.D.** ADDRESS **VAH, Fort Howard, Md.** DATE SIGNED **12-31-55**

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	DATE THEREOF 1/3/56	NAME OF CEMETERY OR CREMATORY Arbutus Memorial Park	LOCATION (City, town, or county) (State) Arbutus, Maryland
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DATE REC'D BY LOCAL REGISTRAR 1-3-56	REGISTRAR'S SIGNATURE W. H. Hedrick	24. FUNERAL DIRECTOR Charles G. Cooper	ADDRESS 512 N. Carrollton Ave. Baltimore, Md.
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MARGIN RESERVED FOR BINDING



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11653

CERTIFICATE OF DEATH

11651

Reg. Dist. No. 45

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Rosedale</u>		Life		TOWN <u>Rosedale</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>760 1/2 Phila. Rd.</u>				STREET ADDRESS (If rural give location) <u>760 1/2 Phila. Rd.</u>			
3. NAME OF DECEASED (Type or Print) <u>Henry John Kohl (Also known as John H. Kohl)</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Dec. 19, 1955</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Aug. 12, 1895</u>	9. AGE last birthday <u>60</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chauffeur</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Rosedale Pass. Lines</u>		11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>William F. Kohl</u>				14. MOTHER'S MAIDEN NAME <u>Anna E. Schelhouse</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-07-1851</u>		17. INFORMANT & ADDRESS <u>Edward H. Kohl-R F D 2 Box 205 Keyser WV</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
4 IMMEDIATE CAUSE (A) <u>Dissecting Aneurysm</u>						<u>4 hours</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>19</u> to <u>19</u> that I last saw the deceased alive on <u>19</u> and that death occurred at <u>M.</u> from the causes and on the date stated above.							
SIGNATURE <u>John C. Collins, Deputy Medical Examiner</u>				ADDRESS (Street, city, town, state) <u>Balt 22</u>		DATE SIGNED <u>12-20</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12-22-1955</u>		NAME OF CEMETERY OR CREMATORY <u>Zion Lutheran</u>		LOCATION (City, town, or county) (State) <u>Stemmers Run, Maryland.</u>	
REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Mrs. Edith Hurley</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Larsen Funeral Home - 7401 Belair Rd.</u>		ADDRESS	
DATE <u>DEC 22 1955</u>							

RECEIVED

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RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

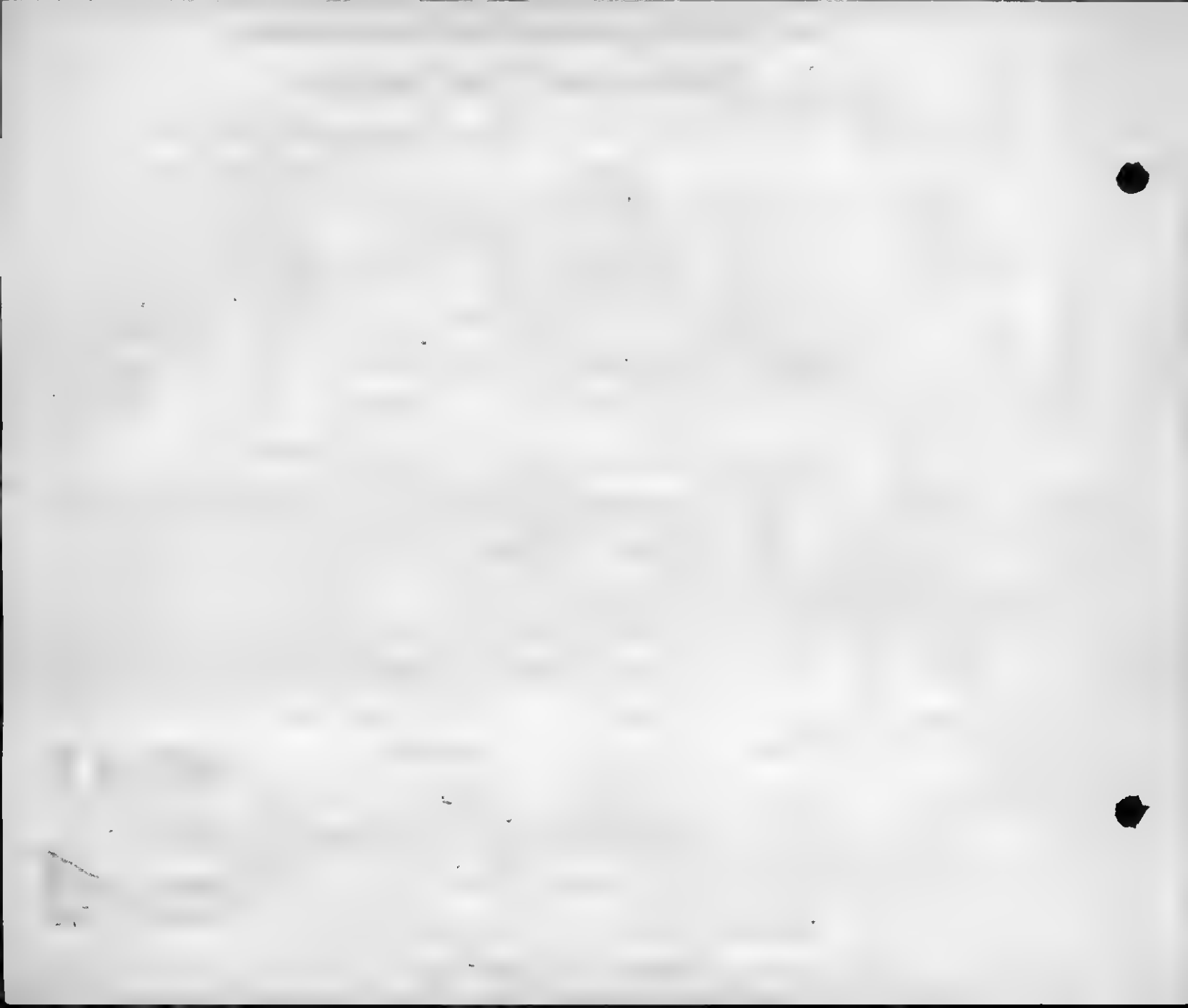
11652

11654

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH COUNTY <u>BALTIMORE</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>52 TOWN CATONSVILLE</u> LENGTH OF STAY (In this place) <u>LIFE</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>317 HARLEM LANE</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u> COUNTY <u>BALTIMORE</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>TOWN CATONSVILLE</u> STREET ADDRESS (If rural give location) <u>317 HARLEM LANE</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>WILLIAM KOLB</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>DEC. 4, 1955</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>JAN. 16 1875</u>	9. AGE last birthday <u>80</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BLDG. CONST.</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN KOLB</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS <u>ELLEN KOLB 317 HARLEM LANE</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 162X IMMEDIATE CAUSE (A) <u>BRONCHOPNEUMONIA C.A.</u> ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.						INTERVAL BETWEEN ONSET AND DEATH <u>14N</u>	
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) M. <input type="checkbox"/> White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10-4</u> , 19 <u>55</u> , to <u>12-4</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12-4</u> , 19 <u>55</u> , and that death occurred at <u>3:30 P.M.</u> from the causes and on the date stated above. SIGNATURE <u>James Estowel</u> M.D. <u>Catonville</u> ADDRESS (Street, city, town, state) <u>12-5</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>12-7-55</u>		NAME OF CEMETERY OR CREMATORY <u>London Park</u>		LOCATION (City, town, or county) (State) <u>BALTIMORE MD.</u>	
24. REC'D BY REGISTRAR <u>1503</u>		REGISTRAR'S SIGNATURE <u>J. B. Harris</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>George L. Shueb</u>		ADDRESS <u>2101 Piedmont Ave.</u>	



11655

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH:

COUNTY Baltimore

MARYLAND

CITY (If outside corporate limits, write RURAL
OR and give nearest town)TOWN TowsonLENGTH OF STAY
(in this place)

5 yrs.

HOSPITAL OR
INSTITUTION OR
STREET ADDRESSPresbyterian Home

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY

CITY (If outside corporate limits, write RURAL and give nearest town)

OR BaltimoreSTREET
ADDRESS

(If rural, give location)

2636 N. Charles St.3. NAME OF
DECEASED:

(First)

(Middle)

(Last)

JESSIE B.KYAUSS

4. DATE

(Month)

(Day)

(Year)

OF

DEATH: BPC.3419 55

5. SEX:

Female

6. COLOR OR
RACE:

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify):

Widow

8. DATE OF BIRTH:

Dec. 4, 1869

9. AGE last birthday:

86 yrs. yrs.

IF UNDER 1 YEAR

Months

Days

IF UNDER 24 HRS.

Hours

Min.

10a. USUAL OCCUPATION (Give kind of
work done during most of working life,
even if retired):

None

10b. KIND OF BUSINESS OR
INDUSTRY:

None

11. BIRTHPLACE (State or foreign country):

Harford Co., Maryland

12. CITIZEN OF WHAT
COUNTRY?

U.S.A.

13. FATHER'S NAME:

Josiah V. Bell

14. MOTHER'S MAIDEN NAME:

Cornelia J. Mitchell

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unk.) (If Yes, give war or dates of
service)

NO.

16. SOCIAL SECURITY No.:

None

17. INFORMANT & ADDRESS:

Towson, Maryland

Mrs. Elliott Presbyterian Home of Maryland

Supt.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause

(a)

DUE TO

Antecedent cause(s)

(b)

DUE TO

Diseases or conditions, if any,
giving rise to the above cause
stating underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS:

Conditions contributing to the death but not
related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION:

0

INTERVAL BETWEEN
ONSET AND DEATH

1443X

Heart disease, chronic myocarditis with acute coronary artery disease

Cardio-vascular disease

Hypertensive with arteriosclerosis

Cerebral hemorrhage - hemiplegic (right side)

Unknown

Unknown

Unknown

12/9/55

20. AUTOPSY?

Yes ☐ No ☒21. ACCIDENT
SUICIDE
HOMICIDE

(Specify)

PLACE (Home, farm, factory, street,
OF office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)
OF INJURYINJURY OCCURRED
While at Not while
work ☐ at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec. 7, 1955, to Dec. 24, 1955, that I last saw the deceased
alive on Dec. 24, 1955, and that death occurred at 11:25 p.m., from the causes and on the date stated above.

SIGNATURE

(DEGREE OR TITLE) ADDRESS

DATE SIGNED

Rollin C. Hudson M.D.Towson 4 Md12/24/5523. BURIAL, CREMATION
REMOVAL (Specify):

Burial

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

Dec. 28, 1955

Loudon Park Cemetery

Baltimore City, Maryland

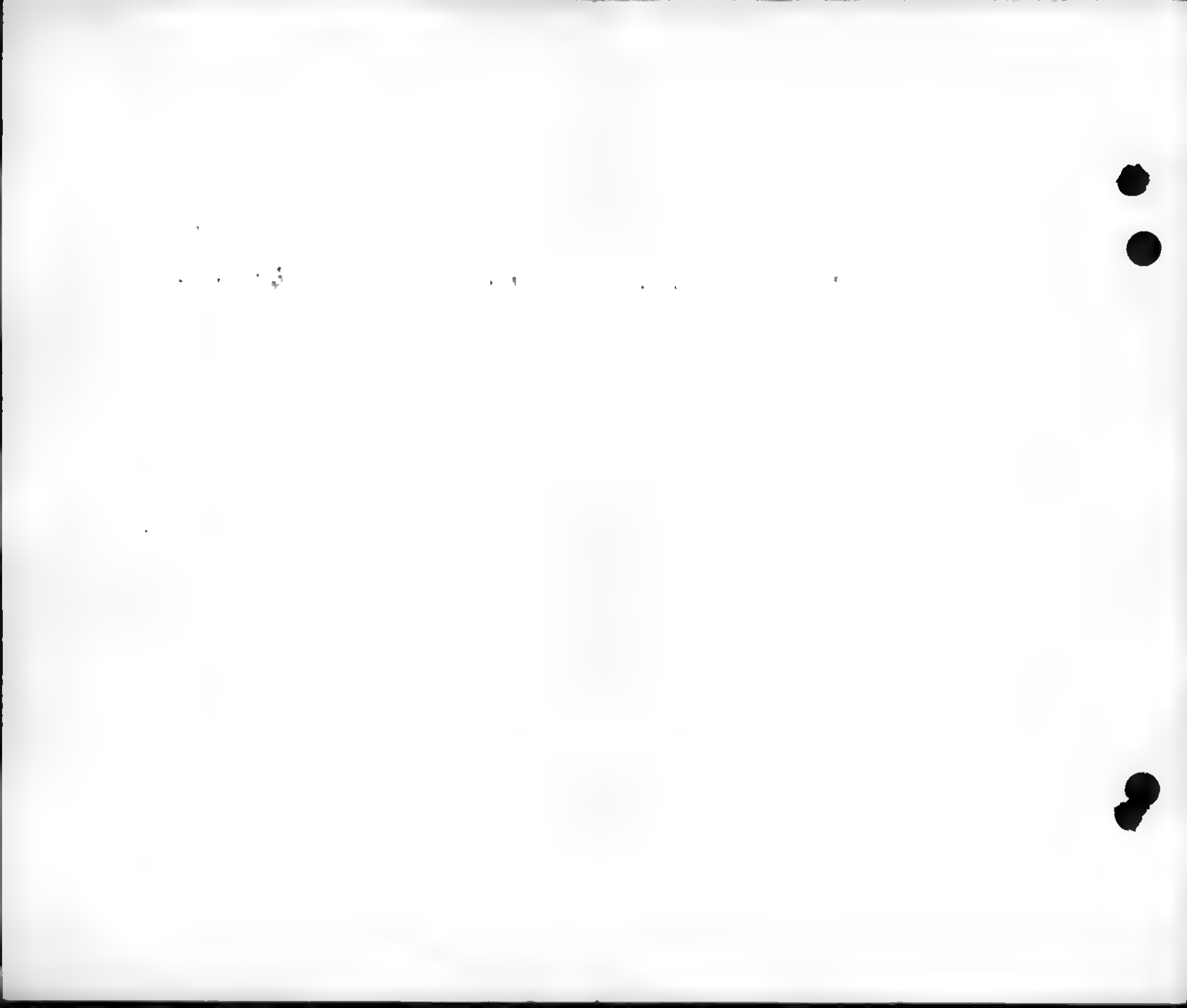
DATE REC'D BY LOCAL
REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

John O. Mitchell & Sons Inc.



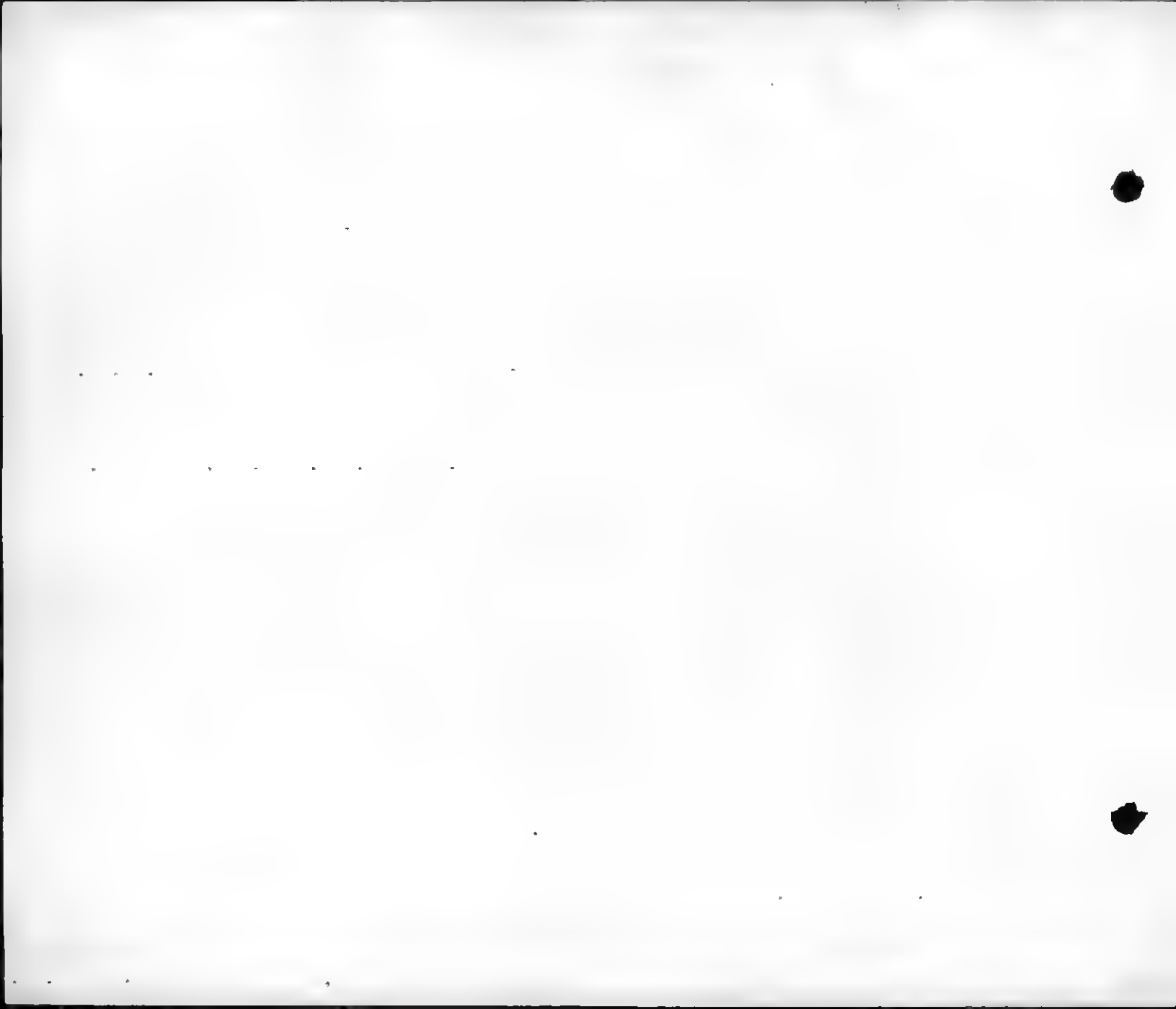
11656 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>			
X TOWN <u>Fort Howard</u>		4 Days					
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location) <u>923 N. Calvert Street</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH: <u>December 19, 1955</u>			
(Type or Print) <u>MILTON KURLAND</u>							
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>12-10-03</u>	9. AGE last birthday: <u>52</u> yrs.	IF UNDER 1 YEAR: Months Days	IF UNDER 24 HRS.: Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Repair Man</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Bethlehem Steel Co.</u>		11. BIRTHPLACE (State or foreign country): <u>Dvinsk, Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME: <u>Ellis Kurland</u>				14. MOTHER'S MAIDEN NAME: <u>Sara Schine</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT & ADDRESS: <u>Clin. Rec. Vet. Adm. Hosp., Ft. Howard, Md.</u>			
(If Yes, give war or dates of service) <u>WW II</u>							
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.1 IMMEDIATE CAUSE (A) <u>ARTERIOSCLEROTIC CORONARY THROMBOSIS</u>						RECENT	
ANTECEDENT CAUSE (B) DUE TO <u>ARTERIOSCLEROSIS, GENERALIZED</u>						UNKNOWN	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>PNEUMONITIS, RIGHT LOWER LOBE</u>						RECENT	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec. 15, 1955</u> , to <u>Dec. 19, 1955</u> that I last saw the deceased alive on <u>Dec. 19, 1955</u> , and that death occurred at <u>9:40 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Francis G. Dickey</u>				DATE SIGNED <u>Dec. 20-55</u>			
Francis G. Dickey, M.D., Chief, Medical Service				VAH, FORT HOWARD, MARYLAND			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		12-21-1955		Windsor Mill Road Cemetery		Baltimore, Maryland	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
12-21-55		<u>[Signature]</u>		Jack Lewis, Inc.		2100 Eutaw Place, Balto. Md.	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



11657

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

COUNTY Baltimore

MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town) TowsonLENGTH OF STAY (in this place) 7 monthsHOSPITAL OR INSTITUTION OR STREET ADDRESS Sheppard-Pratt Hospital
Towson, Md.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland

COUNTY

CITY (If outside corporate limits, write RURAL and give nearest town) Baltimore CitySTREET ADDRESS (If rural give location) Roland Pk. Apts.,

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

LUCYNEWELLLANE

4. DATE OF DEATH:

(Month)

(Day)

(Year)

Dec.161955

5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH:

9. AGE last birthday:

IF UNDER 1 YEAR IF UNDER 24 HRS.

FemaleWhiteWidowJune 28, 187481

yrs.

Months Days Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired):

Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

at home

11. BIRTHPLACE (State or foreign country):

Newfoundland

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME:

John Newell

14. MOTHER'S MAIDEN NAME:

Jane Sommers

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

No

16. SOCIAL SECURITY No.:

none

17. INFORMANT & ADDRESS:

Hospital records

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

422.1
Immediate cause(a) Chronic myocarditis

DUE TO

Antecedent causes (s)Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.(b) Arteriosclerosis

DUE TO

(c)

Interval Between Onset And Death

1 year +3 years +

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.Senile psychosis due to arteriosclerosis.

20. AUTOPSY?

Yes ☐ No ☒

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 24, 1955, to Dec. 16, 1955, that I last saw the deceased alive on Dec. 16, 1955, and that death occurred at 11:45 P., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

M. Elgin M.D.Assistant Med. Supt.Towson 4, Md.Dec. 17, 1955

23. BURIAL, CREMATION, REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

Removal-Burial12/19/55Rock Hill Cem.Foxboro, Mass.

DATE RECD BY LOCAL REGISTRAR

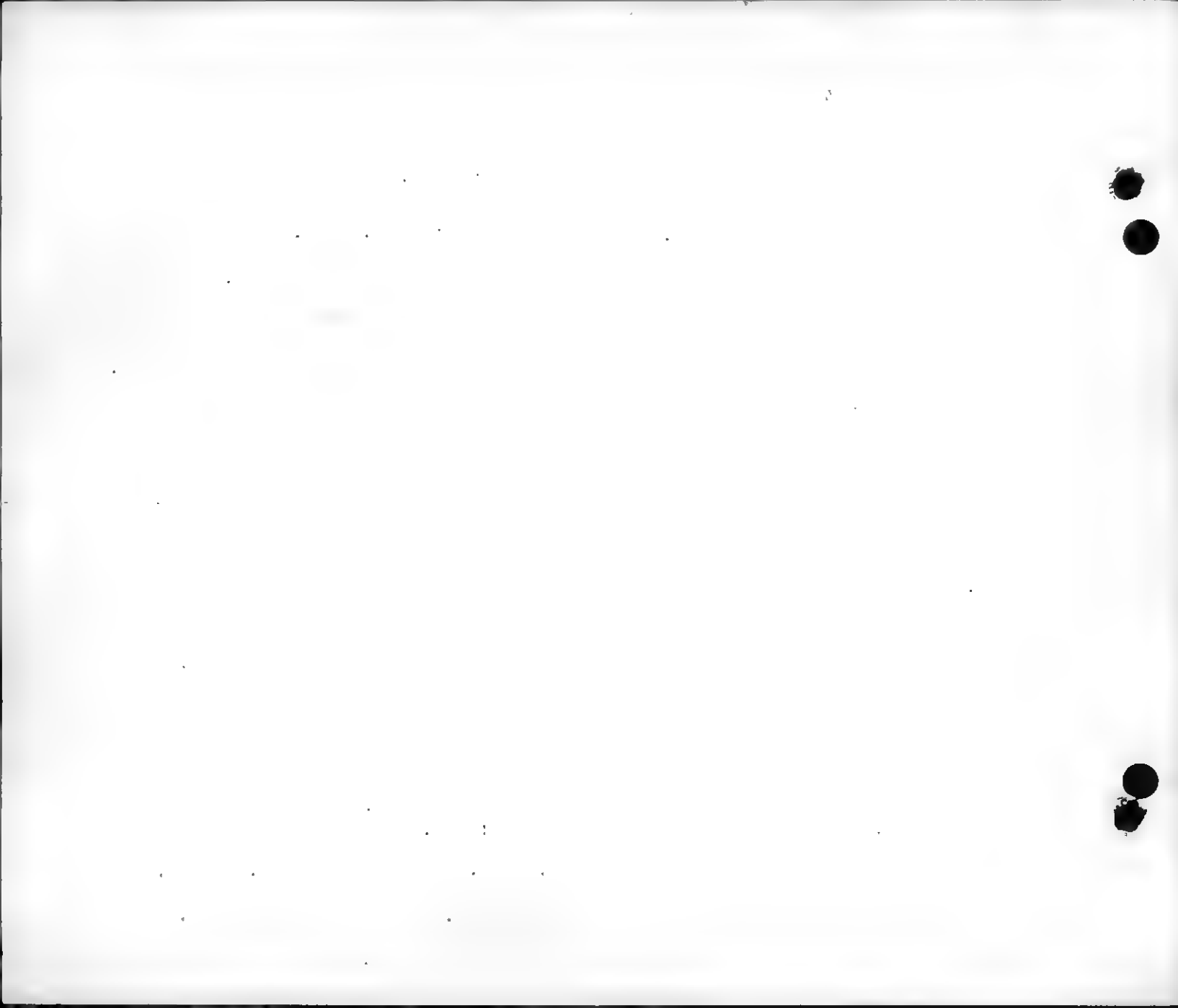
REGISTRAR'S SIGNATURE

FUNERAL DIRECTOR

ADDRESS

12-19-55Dr. ElginDr. ElginThos. J. Tichener & Sons - Balto 17, Mdonce

MARGIN RESERVED FOR BINDING



1

INSTRUCTIONS

THE ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

THE FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-7-54 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11658

CERTIFICATE OF DEATH

11656

Reg. Dist. No. 38

1. PLACE OF DEATH 7912 Ruxway Road				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Baltimore		MARYLAND		STATE Maryland		COUNTY Baltimore City	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
OR TOWN Riderwood Maryland				OR TOWN Baltimore Maryland			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Jorensen Nursing Home				STREET ADDRESS 223 North Luzerne Avenue			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) Averaguerite C Leach				4. DATE OF DEATH (Month) (Day) (Year) December 10, 1955			
5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) single	8. DATE OF BIRTH December 8, 1890	9. AGE last birthday 65 yrs.	IF UNDER 1 YEAR Months 0 Days 2		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) musician		10b. KIND OF BUSINESS OR INDUSTRY music		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Leach				14. MOTHER'S MAIDEN NAME Joanna Heaphy			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY NO. unknown		17. INFORMANT & ADDRESS Mrs. Leah Leach			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
443X IMMEDIATE CAUSE (A) Cerebral hemorrhage acute				few hours			
ANTECEDENT CAUSE(S) DUE TO (B) Hypertension arterial				5 years			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Myocarditis chronic				5 years			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Hypertrophy myocardium.				5 years			
19a. DATE OF OPERATION none		19b. MAJOR FINDINGS OF OPERATION no operation		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) no injury			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) no injury M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? no injury			
22. I hereby certify that I attended the deceased from II-11-1955, to 12-10-1955, that I last saw the deceased alive on 12-6-1955, and that death occurred at 10:20 A.M. from the causes and on the date stated above.							
SIGNATURE James Graham Manton				ADDRESS (Street, city, town, state) 516 Cathedral Street Baltimore Md.		DATE SIGNED 1955	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 12-13-55		NAME OF CEMETERY OR CREMATORY New Cathedral Cem.		LOCATION (City, town, or county) Baltimore Md.	
24. REC'D BY REGISTRAR DATE 12-13-55		REGISTRAR'S SIGNATURE Mabel Gray		25. FUNERAL DIRECTOR'S SIGNATURE B. Dabrowski		ADDRESS 2818 E. Baltimore St.	

BUREAU V. S.

DEC 14 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

11659
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11657
 Reg. Dist.

No. 39

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>X TOWN RURAL - MONKTON</u>				CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Monkton P.O.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Hess Road near Manor Rd.</u>				STREET ADDRESS (If rural, give location) <u>Hess Road Near Manor Road</u>			
3. NAME OF DECEASED: (Type or Print) <u>Charles HENRY Lee</u>				4. DATE OF DEATH <u>Dec. 7 1955</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>Feb. 23, 1889</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>Horse Trainer</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Estate</u>		9. AGE last birthday: <u>66</u> yrs.		11. BIRTHPLACE (State or foreign country): <u>New Jersey</u>	
13. FATHER'S NAME: <u>John Henry Lee</u>				14. MOTHER'S MAIDEN NAME: <u>Clara McBakley</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY No.: <u>212-32-1580</u>		17. INFORMANT & ADDRESS: <u>Ella M. Lee, Hess Rd., Monkton, Md.</u>			
15. (If Yes, give war or dates of service) <u>None</u>							
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
<u>420.1</u> Immediate cause (a)..... <u>Coronary occlusion</u> DUE TO Antecedent cause(s) (b)..... Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c).....							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>E. M. France</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/> <u>12/6/55</u>					
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>Dec. 10, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Woodbury Memorial Cemetery</u>		LOCATION (City, town, or county) (State) <u>Woodbury, New Jersey</u>	
DATE REC'D BY LOCAL REG. <u>12/10/55</u>		REGISTRAR'S SIGNATURE <u>M. Elizabeth G. Welch</u>		24. FUNERAL DIRECTOR <u>John B. Soma</u>		ADDRESS <u>Towson, Maryland</u>	

U.S. AIR FORCE

RECEIVED
11 FEB 1954
11



12574

MARYLAND

STATE DEPARTMENT OF HEALTH

11661 CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH COUNTY <u>Baltimore County</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE _____ COUNTY _____	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Owings Mills, Md.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Merryman's A.e., Waverly, Md.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Rosewood St. Training School.</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>Clarence</u>		4. DATE OF DEATH (Month) <u>12</u> (Day) <u>30</u> (Year) <u>1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>	8. DATE OF BIRTH <u>1898</u> <u>57</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9. AGE last birthday If under 1 year: Months _____ Days _____ If under 24 hrs: Hours _____ Min. _____	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore City</u>	
13. FATHER'S NAME <u>Charles E. Legare</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) <u>no</u>		14. MOTHER'S MAIDEN NAME <u>Martha M. Hare</u>	
16. SOCIAL SECURITY NO. ----		17. INFORMANT AND ADDRESS <u>Rosewood records</u>	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
471X Immediate cause (a)..... Acute bronchitis				1 day	
Antecedent cause(s)				1 day	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		(b)..... Broncho-pneumonia		2 yrs of age	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		(c)..... Meningo-encephalitis with symptomatic epilepsy			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, or office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>12/29/</u> , 1955, to <u>12/30/</u> , 1955, that I last saw the deceased alive on <u>12/30/</u> , 1955, and that death occurred at <u>3:50 a.m.</u> , from the causes and on the date stated above.					
SIGNATURE <u>Mary S. Butler M.D.</u>		ADDRESS <u>Owings Mills, Maryland.</u>		DATE SIGNED <u>12/30/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE <u>JAN 3 1956</u>		NAME OF CEMETERY OR CREMATORY <u>UOFM MEDICAL SCHOOL</u>	
DATE REC'D BY CLERK <u>JAN 15 1956</u>		REGISTRAR'S SIGNATURE <u>Mary Elise</u>		LOCATION (City, town, or county) (State) <u>29 S GREENE ST MD</u>	
		24. FUNERAL DIRECTOR		ADDRESS <u>1800 F LOMBARD ST</u>	

MARGIN RESERVED FOR BINDING

RECEIVED

RECEIVED

11662

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Owings Mills</u> LENGTH OF STAY (in this place) <u>16 yrs.</u>		STATE <u>Maryland</u> COUNTY <u>Carroll</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Westminster</u> <u>Ch-27-2</u> STREET ADDRESS (If rural give location)	
12. HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Rosewood State Tr. School</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Rosemary</u> <u>-</u> <u>Leister</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>12</u> <u>3</u> <u>19 55</u>	
5. SEX. <u>female</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>single</u>	8. DATE OF BIRTH: <u>4/17/25</u>
9. AGE last birthday <u>30</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>-</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>-</u>	11. BIRTHPLACE (State or foreign country): <u>Ohio</u>
13. FATHER'S NAME: <u>Benjamin Payne Leister</u>		14. MOTHER'S MAIDEN NAME: <u>Matilda Neisel</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>-</u>		17. INFORMANT & ADDRESS: <u>Rosewood Records</u>	
16. SOCIAL SECURITY NO. <u>-</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
4-71X IMMEDIATE CAUSE (A) <u>Confluent broncho-pneumonia in both</u>			<u>2 days</u>
ANTECEDENT CAUSE (B) <u>lower lobes.</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Epilepsy-Etiology undetermined</u>			<u>1 yr. of age</u>
19A. DATE OF OPERATION: <u>-</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>12/1</u> , 19 <u>55</u> , to <u>12/3</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12/3</u> , 19 <u>55</u> , and that death occurred at <u>9:05 p.m.</u> from the causes and on the date stated above.			
SIGNATURE <u>Harry B. Butler</u>		ADDRESS <u>Owings Mills, Md.</u> DATE SIGNED <u>12/6/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>	DATE THEREOF <u>12-7-55</u>	NAME OF CEMETERY OR CREMATORY <u>Kridders</u>	LOCATION (City, town, or county) (State) <u>Westminster Md</u>
DATE REC'D BY LOCAL REGISTRAR <u>12-7-55</u>	REGISTRAR'S SIGNATURE <u>Mary B. Elmer</u>	FUNERAL DIRECTOR <u>Glenn F. Seitz</u> ADDRESS <u>5209 York Rd Balt. Md</u>	

MARGIN RESERVED FOR BINDING

VS. A15--10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU Y. S.

DEC 12 1965

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

11663

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11660
Reg. Dist. No. 40

1. PLACE OF DEATH: COUNTY <u>Balto</u> MARYLAND CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Chase</u> TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Md</u> COUNTY <u>Balto</u> CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Chase</u> STREET ADDRESS <u>Box 294 Rt 16 Jm 20 Baltimore</u> (If rural, give location)	
3. NAME OF DECEASED: (Type or Print) (First) <u>Albert</u> (Middle) <u>James</u> (Last) <u>Leonard</u>		4. DATE OF DEATH (Month) <u>12</u> (Day) <u>28</u> (Year) <u>1955</u>	
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): <u>married</u>	8. DATE OF BIRTH: <u>9-29-13</u>
9. AGE last birthday: <u>42</u> yrs.		10. BIRTHPLACE (State or foreign country): <u>Md</u>	
11. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Electrician</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>Albert James Leonard</u>		14. MOTHER'S MAIDEN NAME: <u>Emma K. Langer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service) <u>None</u>		16. SOCIAL SECURITY No.: <u>212-10-9869</u>	
17. INFORMANT & ADDRESS: <u>Helen E. Leonard (same)</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: <u>812X</u> Immediate cause (a) <u>Compound fractures of spine, cervical vertebrae, left femur, tibia & fibula</u> DUE TO Antecedent cause(s) (b) <u>Multiple fracture of other bone</u> DUE TO Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <u>None</u>			INTERVAL BETWEEN ONSET AND DEATH
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: <u>None</u>			
19a. DATE OF OPERATION: <u>None</u>		19b. MAJOR FINDING OF OPERATION: <u>None</u>	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		21. HOW DID INJURY OCCUR? <u>Crossed R.R. Crossing in front of Train</u>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, street, bldg., etc.) OF INJURY: <u>Chase Box 294</u>	
21c. (City or town) (County) (State): <u>Chase Balto Md</u>		21d. TIME (Month) (Day) (Year) (Hour) OF INJURY: <u>12-28-55 7:03 P.M.</u>	
21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Crossed R.R. Crossing in front of Train</u>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <u>M. B. Davis M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>12/28/55</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF: <u>12/31/55</u>	
NAME OF CEMETERY OR CREMATORY: <u>Ebenezer Cemetery</u>		LOCATION (City, town, or county) (State): <u>Balto Co Md</u>	
DATE REC'D BY LOCAL REG: <u>12/30/55</u>		REGISTRAR'S SIGNATURE: <u>G. L. Redman</u>	
24. FUNERAL DIRECTOR: <u>Boydman 1407 Eastern Ave</u>		ADDRESS	



11664

11661

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

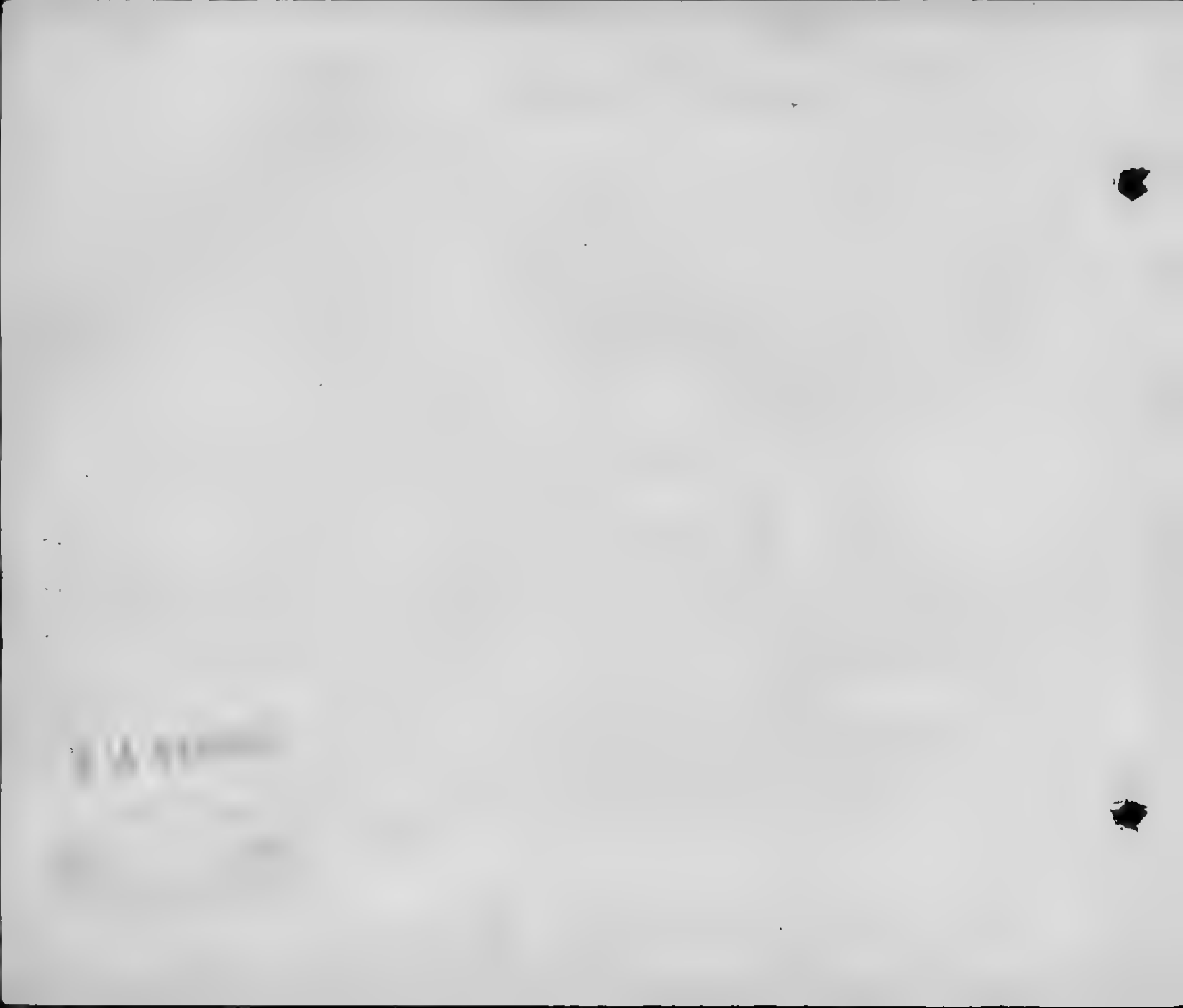
Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 33...

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Baltimore		MARYLAND		STATE Md		COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Reisterstown		LENGTH OF STAY (in this place) 8 yrs		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Reisterstown			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 117 Chatsworth Ave.				STREET ADDRESS (If rural, give location) 117 Chatsworth Ave.			
3. NAME OF DECEASED: (First) (Middle) (Last) (Type or Print) Joseph Luther Lippy				4. DATE OF DEATH (Month) (Day) (Year) Dec. 15 19 55			
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH: Jan. 15, 1883	9. AGE last birthday: 72 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Farm Employee		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): Carroll Co.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Thomas Lippy				14. MOTHER'S MAIDEN NAME: Jane Harris			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) no		16. SOCIAL SECURITY No.: none		17. INFORMANT & ADDRESS: William Lippy, Randallstown, Md.			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a)..... Cystitis and Pyelitis						5 mos.	
DUE TO							
Antecedent cause(s) (b)..... Urinary Incontinence						6 mos.	
Diseases or conditions, if any, giving rise to the above cause DUE TO							
stating underlying cause last (c)..... Arteriosclerosis						3 yrs.	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Fractured right hip						7 mos.	
19a. DATE OF OPERATION: May, 1955		19b. MAJOR FINDING OF OPERATION: Fractured right hip				20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. none		21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) Home		21c. (City or town) (County) 117 Chatsworth Ave., Reisterstown, Md.		(State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY May 6, 1955 7P M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? Lost balance and fell.			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE R.D. Eline		M. D.		CHIEF MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>		DATE SIGNED 12-15-55	
23. BURIAL, CREMATION, REMOVAL (Specify): Burial		DATE THEREOF Dec 19 1955		NAME OF CEMETERY OR CREMATORY Leisters		LOCATION (City, town, or county) (State) Carroll County, Md.	
DATE REC'D BY LOCAL REG. 12-16-55		REGISTRAR'S SIGNATURE Mary B. Eline		24. FUNERAL DIRECTOR J.F. Eline & Sons, Reisterstown, Md.			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11662

11665

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Riderwood</u>		LENGTH OF STAY (In this place) <u>4 months</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Owings Mills</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sorsenson Nursing Home</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (First) (Middle) (Last) <u>Laura Eleanor Long</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Dec. 25, 1955</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Jan. 18, 1883</u>	9. AGE last birthday <u>72</u> yrs.	IF UNDER 1 YEAR Months <u>11</u> Days <u>7</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore County</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Nathan Hanson</u>				14. MOTHER'S MAIDEN NAME <u>Laura V. Johnson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Jr. C. Albert Long, Owings Mills, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>pulmonary embolism</u>						<u>3 days</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (B) <u>Coronary atherosclerosis</u>						<u>5 years</u>	
STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Hypertrophy myocardium</u>						<u>5 years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>arteriosclerosis generalized</u>						<u>10 years</u>	
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION <u>no operation</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>no injury</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) <u>none</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>no injury</u>			
22. I hereby certify that I attended the deceased from <u>Aug. 31, 1955</u> to <u>Dec. 5, 1955</u> that I last saw the deceased <u>alive on</u> <u>Dec. 5, 1955</u> and that death occurred at <u>4:25 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Thomas Graham Harrison, M.D.</u>				ADDRESS (Street, city, town, state) <u>516 Cathedral St Baltimore County</u>		DATE SIGNED <u>12-27-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Dec. 29, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Jessons</u>		LOCATION (City, town, or county) (State) <u>Baltimore County</u>	
24. REC'D BY REGISTRAR <u>12-28-55</u>		REGISTRAR'S SIGNATURE <u>Mary B. Elive</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J.F. Eline & Sons, Reisterstown, Md.</u>		ADDRESS	

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11663

11666 CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		STATE <u>Maryland</u>		COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>		LENGTH OF STAY (in this place) <u>5 Days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>		STREET ADDRESS (If rural give location) <u>5136 Belair Road</u>					
3. NAME OF DECEASED (Type or Print) <u>HENRY J. LURZ, SR.</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>December 20 19 55</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>2-25-93</u>	9. AGE last birthday <u>62</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Postal Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Government</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Francis Lurz</u>				14. MOTHER'S MAIDEN NAME <u>Wilhelmina MN: Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u> <u>WW I</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT & ADDRESS <u>Clin. Rec. Vet. Adm. Hosp., Ft. Howard, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>OBSTRUCTION OF COLON</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO <u>UNDETERMINED CAUSE</u>						<u>10 DAYS</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO <u>MYOCARDIAL INFARCTION</u>							
STATING UNDERLYING CAUSE LAST, DUE TO <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u>						<u>3 DAYS UNKNOWN</u>	
19a. DATE OF OPERATION <u>12-16-55</u>		19b. MAJOR FINDINGS OF OPERATION <u>Colostomy - transverse</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min) <u>M.</u>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that <u>VA</u> attended the deceased from <u>Dec. 15</u> , 19 <u>55</u> , to <u>Dec. 20</u> , 19 <u>55</u> , and that death occurred at <u>7:45 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Joseph M. Miller</u>				ADDRESS (Street, city, town, state) <u>VAH, FORT HOWARD, MARYLAND 12-21-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12-23-55</u>		NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
24. REC'D BY REGISTRAR <u>135</u>		REGISTRAR'S SIGNATURE <u>Dawson L. Farley</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook-Blight, Inc.</u>		ADDRESS <u>6009 Harford Rd. Balto. Md.</u>	

RECEIVED

DEC 28 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11667

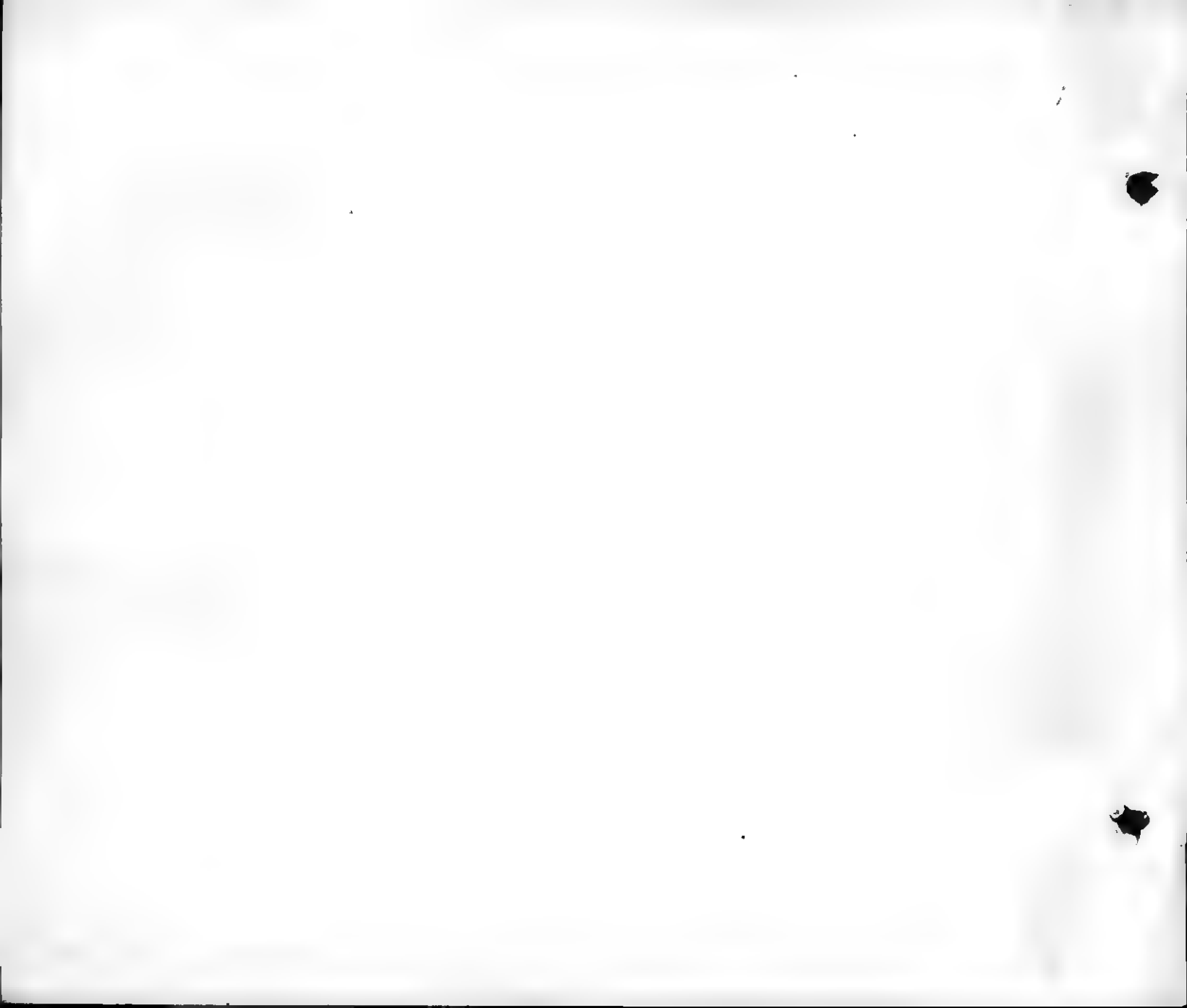
CERTIFICATE OF DEATH

11664

Item 2, Film G190 12-13-55 et

Reg. Dist. No. 22...

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Md</u>	COUNTY <u>3 Vol 4</u>
CITY (If outside corporate limits, write OR and give nearest town)	RURAL LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write OR and give nearest town)	
TOWN <u>Louise Valley Md.</u>	<u>16 months</u>	TOWN <u>Dyersburg, Md.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS	
<u>90 Stella Maris Hospice</u>		<u>1100 N. Market St. Baltimore City</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <u>Jane</u>	(Middle) <u>Lynne</u>	(Month) <u>12</u>	(Day) <u>4</u> (Year) <u>1955</u>
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>single</u>	8. DATE OF BIRTH: <u>12/7/1876</u>
9. AGE last birthday: <u>78</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION: Give kind of work done during most of working life, even if retired: <u>house work</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>at home</u>	
11. BIRTHPLACE (State or foreign country): <u>Ireland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>William Lynne</u>		14. MOTHER'S MAIDEN NAME: <u>Elizabeth Kiernan</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>Yes</u>		16. SOCIAL SECURITY No.: <u>12620</u>	
17. INFORMANT & ADDRESS: <u>M. Ralph Schreiber Epping Rd.</u>			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			Interval Between Onset And Death
433.0 Immediate cause (a) <u>Asencia</u>			<u>10 weeks</u>
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <u>Adams Stakes Syndrome causing Cerebral Thrombosis</u>			<u>5 months</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION	
0			
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan., 1955, to Dec., 1955, that I last saw the deceased alive on Dec 4, 1955, and that death occurred at 5:30 PM, from the causes and on the date stated above.			
SIGNATURE <u>Charles F. O'Donnell</u>		ADDRESS <u>2501 York Rd. Towson #4</u>	
DATE THEREOF <u>12/9/55</u>		DATE SIGNED <u>12/5/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		NAME OF CEMETERY OR CREMATORY	
<u>Burial</u>		<u>New Cathedral C.M.</u>	
LOCATION (City, town, or county) (State)			
<u>4300 Old Frederick Rd.</u>			
DATE REC'D BY LOCAL REGISTRAR		24. FUNERAL DIRECTOR	
<u>12-5-55</u>		<u>John J. Bowman & Son</u>	
REGISTRAR'S SIGNATURE		ADDRESS	
<u>John J. Bowman & Son</u>		<u>29 Collins St.</u>	



1

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2 **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11668 CERTIFICATE OF DEATH

11665

Reg. Dist. No. 30

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTIMORE</u>		STATE <u>MD</u>		COUNTY <u>BALTIMORE</u>			
CITY OR TOWN <u>CATONSVILLE</u>		LENGTH OF STAY (in this place) <u>5 month</u>		CITY OR TOWN <u>BALTIMORE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>SPRING GROVE</u>		STREET ADDRESS (if rural give location) <u>2634 HAPDEN AV.</u>					
3. NAME OF DECEASED (Type or Print) <u>MARY MAGNESS</u>				4. DATE OF DEATH (Month) <u>12</u> (Day) <u>9</u> (Year) <u>1955</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>M</u>	8. DATE OF BIRTH <u>4/26/1877</u>	9. AGE last birthday <u>78</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>WILLIAMS WILLINGHAM</u>				14. MOTHER'S MAIDEN NAME <u>SARAH FOWLER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>—</u> (If Yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT & ADDRESS <u>HOSPITAL RECORDS</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Arteriosclerotic cardiovascular disease with hypertension</u>						INTERVAL BETWEEN ONSET AND DEATH <u>years</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Senility</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>—</u>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. PLACE (Home, farm, factory, of injury street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. _____		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>6/29</u> , 19 <u>55</u> , to <u>12/9</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12/9</u> , 19 <u>55</u> , and that death occurred at <u>1235 PM</u> from the causes and on the date stated above.							
SIGNATURE <u>Stella Wacholer</u>				ADDRESS (Street, city, town, state) <u>M.D. Spring Grove St. Hosp.</u>		DATE SIGNED <u>12/9/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>12-12-1955</u>		NAME OF CEMETERY OR CREMATORY <u>PARKWOOD</u>		LOCATION (City, town, or county) (State) <u>BALTIMORE, MD.</u>	
24. REC'D BY REGISTRAR <u>DEC 13 1955</u>		REGISTRAR'S SIGNATURE <u>T. E. Barry</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Lanahan Funeral Home-7401 Belair Rd.</u>		ADDRESS	

31

500

1000

MARYLAND STATE DEPARTMENT OF HEALTH
11669 CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

11666

Reg. Dist. No. 38

1. PLACE OF DEATH COUNTY Baltimore		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL and give nearest town) Parkville		CITY (If outside corporate limits, write RURAL and give nearest town) Parkville	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 2900 Chenoak Avenue		STREET ADDRESS (If rural, give location) 2900 Chenoak Avenue	
3. NAME OF DECEASED (Type or Print) Mr. Charles Thomas Marsh		4. DATE OF DEATH (Month) December (Day) 15th (Year) 1955	
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married	8. DATE OF BIRTH Mar. 11, 1909
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Newspaper Carrier		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Marsh		14. MOTHER'S MAIDEN NAME Emma	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS Mrs. Helen Moores Marsh, 2900 Chenoak Ave.			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <i>Pneumonia</i>		
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		
(c)		

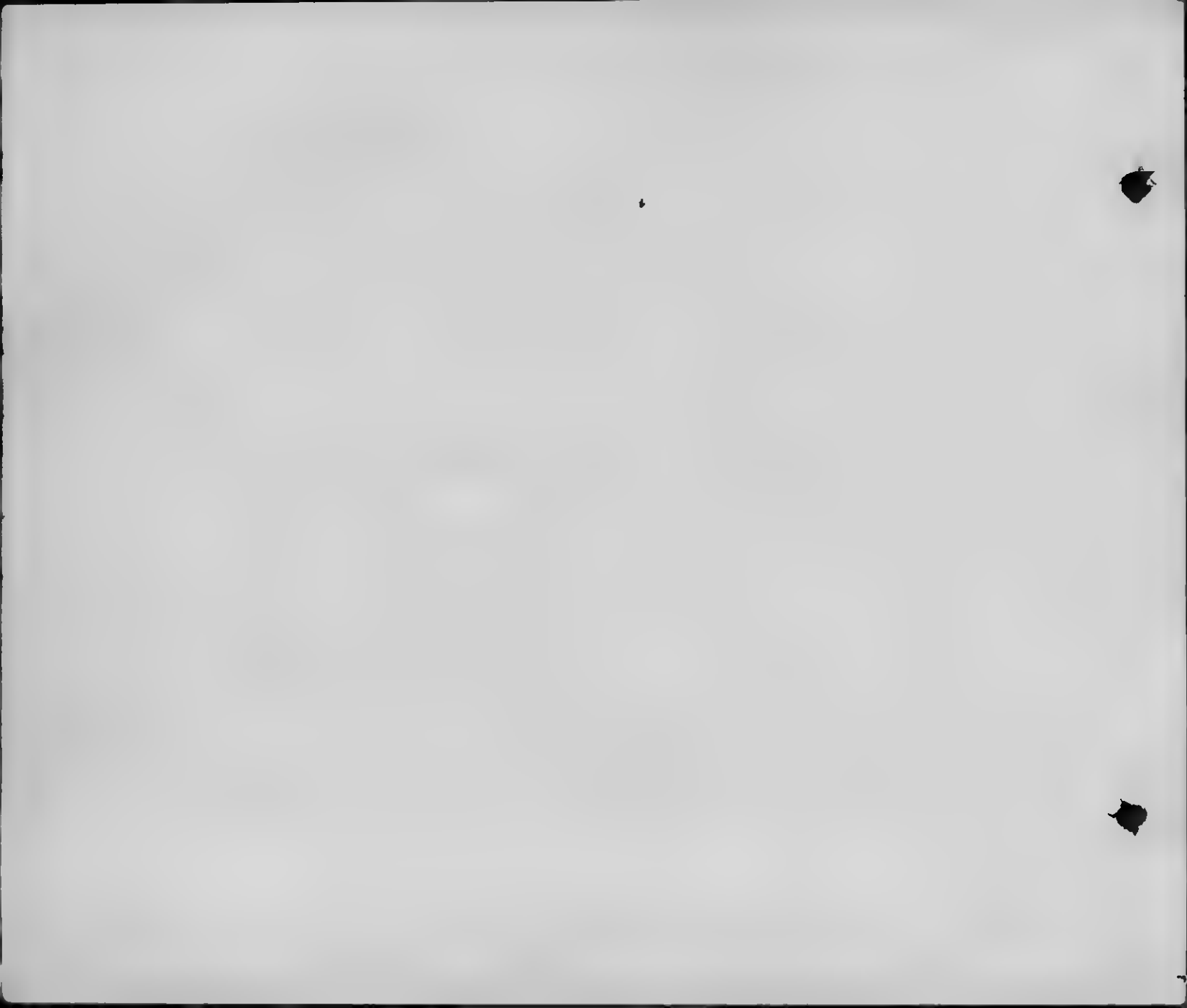
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes, accident, suicide, homicide, undetermined.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
<i>Leonard J. Kuck</i>		
24. FUNERAL DIRECTOR	ADDRESS	
Leonard J. Kuck, 305 Harford Road		

MARGIN RESERVE FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.



11667

MARYLAND STATE DEPARTMENT OF HEALTH

11670 - CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 37

Item 2, File G190 12-27-55 et

1. PLACE OF DEATH - COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Lutherville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 10</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>College Manor Nursing Home</u>		STREET ADDRESS (If rural, give location) <u>Prior to 9-11-52) 106 Woodlawn Road</u>	
3. NAME OF DECEASED (First) <u>Mattie</u> (Middle) <u>A</u> (Last) <u>Martenet</u>		4. DATE OF DEATH (Month) <u>Dec.</u> (Day) <u>16</u> (Year) <u>1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>June 18, 1859</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>	9. AGE last birthday <u>96</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Mln.
11. BIRTHPLACE (State or foreign country) <u>Baltimore Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Henry Lange</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Westerman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. George Ely 3411 Oakenshawe Place</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
44 X Immediate cause (a) <u>Congestive Heart Failure</u>		<u>1 wk</u>
Antecedent cause(s) (b) <u>myocarditis</u>		<u>Gradual</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>hypertension</u>		<u>✓</u>
II. OTHER SIGNIFICANT CONDITIONS (Conditions contributing to the death but not related to the disease or condition causing death.) <u>Chronic Hypertrophic Cardiomyopathy</u>		<u>✓</u>
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. DATE OF CREMATION <u>12/19/55</u>	NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>	LOCATION (City, town, or county) <u>Baltimore, Md.</u>
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DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

DEC 18 1955

Miss Anne D. MacKinnon

No. W. Meade & Sons 27 Calvert St.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Doc

1

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C (53) JMA

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11671 **CERTIFICATE OF DEATH**

11668

Reg. Dist. No. 30

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTO. CO</u>		STATE <u>MD</u> COUNTY <u>BALTO</u>		CITY (If outside corporate limits, write RURAL or and give nearest town) <u>CATONSVILLE</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>	
TOWN <u>CATONSVILLE</u>		LENGTH OF STAY (In this place)		STREET ADDRESS <u>203 N. ROLLING RD</u>		(If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>203 N. ROLLING RD</u>				STREET ADDRESS <u>203 N. ROLLING RD</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>RACHEL BERTHA MASSEK</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>12/9/55</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>AUG. 14, 1879</u>	9. AGE last birthday <u>76</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wm. H. AMOSS</u>				14. MOTHER'S MAIDEN NAME <u>AMOSS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Thomas N. Massey</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>331X Myocardial-Renal failure</u>				INTERVAL BETWEEN ONSET AND DEATH <u>72 hrs</u>			
ANTECEDENT CAUSE(S) (B) <u>Successive cerebrovascular accidents</u>				<u>9 months</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Arteriosclerosis, generalized</u>				<u>7-8 yrs</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec 12</u> , 19 <u>48</u> , to <u>12-9</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12-8</u> , 19 <u>55</u> , and that death occurred at <u>6:30 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Stephen Lee Hagness</u> M.D.				ADDRESS (Street, city, town, state) <u>Catonsville 28, Md</u>		DATE SIGNED <u>12-10-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>12/12/55</u>		NAME OF CEMETERY OR CREMATORY <u>MT VIEW</u>		LOCATION (City, town, or county) (State) <u>HOWARD CO MD</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>T.E. Harry</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Mac Stark + Son</u>		ADDRESS <u>28</u>	
DATE <u>12/12/55</u>							

BUREAU V. S.

DEC 14 1955

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11669

11672

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH COUNTY <u>Baltimore Co.</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>MARYLAND</u> TOWN <u>Catonville</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>BALTIMORE</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u> COUNTY CITY (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> STREET ADDRESS (If rural give location) <u>1815 WEST BALTIMORE</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>ALMA MARIE</u> <u>McALLISTER</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Dec. 3</u> <u>1955</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>MARCH 12, 1897</u>	9. AGE last birthday <u>64</u> yrs.	10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DIETICIAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOSPITAL</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM H. McALLISTER</u>				14. MOTHER'S MAIDEN NAME <u>ANNA ELIZABETH SCHEUERMANN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>212-01-1540</u>		17. INFORMANT & ADDRESS <u>MISS. EDNA M. McALLISTER</u> <u>3512 FREDERICK AVE.</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
170x IMMEDIATE CAUSE (A) <u>CARCINOMA of the Breast</u>						<u>Aug 1955</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>with generalized metastasis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>12/3/55</u>		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Aug 1955</u> to <u>Dec 3, 1955</u> that I last saw the deceased alive on <u>12/3/55</u> and that death occurred at <u>4 A</u> M, from the causes and on the date stated above.							
SIGNATURE <u>J. B. Davis</u>				DATE SIGNED <u>3512 Frederick Ave. Balto 12/5/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Dec. 6 - 1955</u>		NAME OF CEMETERY OR CREMATORY <u>WESTERN Cem.</u>		LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>	
24. REC'D BY REGISTRAR DATE <u>DEC 3 1955</u>		REGISTRAR'S SIGNATURE <u>J. B. Davis</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>E. Truman Schwal</u>		ADDRESS <u>3512 Frederick Ave. (29)</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

11673

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>md</u> COUNTY <u>Balt</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Pikeville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Pikeville</u>	
TOWN <u>Pikeville</u>		TOWN <u>Pikeville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location) <u>Mc Henry av.</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>Theresa Mary J. McCormick</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Dec. 31 1955</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>March 4, 1885</u>
9. AGE last birthday <u>70</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Baltimore, md</u>	
10a. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) <u>Secretary</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Insurance</u>	
11. FATHER'S NAME <u>Lawrence J. McCormick</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		14. MOTHER'S MAIDEN NAME <u>Deila Johnston</u>	
15. SOCIAL SECURITY No. <u>212-07-0662</u>		16. INFORMANT <u>Ms. Gertrude Laiff</u>	

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) C.V.A. & right hemiplegia

Antecedent cause(s)

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Malignant hypertension(c) Generalized arteriosclerosis

INTERVAL BETWEEN ONSET AND DEATH

4 days

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
SUICIDE	INJURY			
TIME (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		
OF INJURY				

22. I hereby certify that I attended the deceased from March 12, 1955, to 31 Dec, 1955, that I last saw the deceased alive on 31 Dec, 1955, and that death occurred at 7:30 P m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Charles H. Williams, M.P.Pikeville 831 Dec 55

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>Mar 4, 1956</u>	<u>New Federalist</u>	<u>Baltimore, Md</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>JAN 2, 1956</u>	<u>Dorothy A. Newell</u>	<u>Frank H. Newell</u>	<u>Pikeville</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

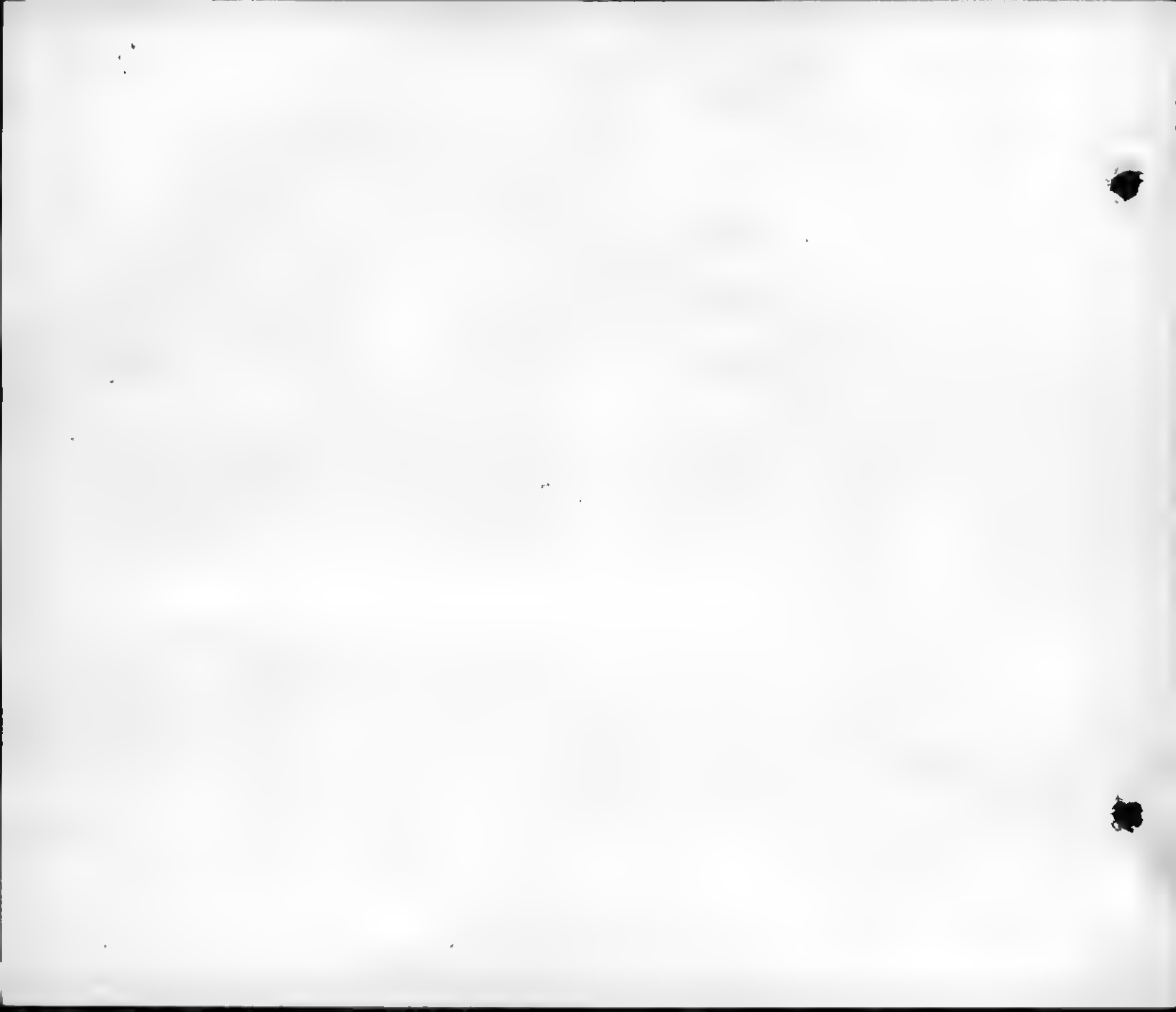
11671

11674

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Mt. Wilson</u>		<u>1121 days</u>		OR TOWN <u>Maryland</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Mt. Wilson State Hospital</u>				STREET ADDRESS (If rural give location) <u>Foreston Road</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
<u>James Webb McCurley</u>				<u>12 15 19 55</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>		8. DATE OF BIRTH: <u>9/17/74</u>	
9. AGE last birthday <u>81</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>Insurance</u>		11. BIRTHPLACE (State or foreign country): <u>Baltimore, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME: <u>Isaac McCurley</u>				14. MOTHER'S MAIDEN NAME: <u>Hannah Ann Stran</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT & ADDRESS: <u>Mr. J. Webb McCurley, Jr. Foreston Rd. Upperco, Md.</u>							
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Far Advanced Pulmonary Tuberculosis</u>						<u>5 years</u>	
ANTECEDENT CAUSE (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Arteriosclerosis, General</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.						<u>Several years</u>	
19A. DATE OF OPERATION: <u>11/19/52</u>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>M.</u>		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11/19, 1952</u> , to <u>12/15, 1955</u> that I last saw the deceased alive on <u>12/15/55</u> 19 <u>55</u> , and that death occurred at <u>2:10 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>William Newman</u>				DATE SIGNED			
M. D.							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12/17/55</u>		NAME OF CEMETERY OR CREMATORY <u>Meadowridge Mem.</u>		LOCATION (City, town, or county) (State) <u>Elkridge, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>12-16-55</u>		REGISTRAR'S SIGNATURE <u>H. C. Hedrick</u>		24. FUNERAL DIRECTOR <u>Thos. G. Pickens</u>		ADDRESS <u>1700 - Balt. 17 Md.</u>	



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11673

11673

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		STATE <u>Maryland</u>		COUNTY <u>Baltimore City</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>52 Catonsville, 28</u>		LENGTH OF STAY (in this place) <u>26yr 2mo 6days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore City</u>		<u>2-5-1-4</u>	
TOWN				STREET ADDRESS (If rural give location) <u>Unknown</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>14 Spring Grove State Hospital Baltimore 28, Maryland</u>							
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Katherine McGreevy</u>				<u>12-5-55</u> 19			
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH	
<u>Female</u>		<u>White</u>		<u>Single</u>		<u>2-27-08</u>	
						9. AGE last birthday yrs. <u>47</u>	
						IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>--</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
						12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wm. McGreevy</u>				14. MOTHER'S MAIDEN NAME <u>Eva Ruppel</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>				16. SOCIAL SECURITY NO. <u>--</u>		17. INFORMANT & ADDRESS <u>Baltimore, 28, Maryland</u> <u>Spring Grove Hospital Records, Md</u>	
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<u>570.5</u> IMMEDIATE CAUSE (A) <u>Intestinal obstruction due to undetermined cause</u>				<u>1 week</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
<u>✓</u>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on <u>12-5-55</u>, and that death occurred at <u>6:30 AM</u>, from the causes and on the date stated above.							
SIGNATURE <u>Bernard J. Fleischmann</u> M.D.				DATE SIGNED <u>12-5-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				24. REC'D BY REGISTRAR			
DATE THEREOF <u>12/10/55</u>				NAME OF CEMETERY OR CREMATORY <u>Sacred Heart Cemetery</u>			
25. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Barry</u>				ADDRESS <u>Spring Grove ST. Hosp.</u>			
26. DATE <u>12-5-55</u>				27. ADDRESS <u>1315 Light St.</u>			

BUREAU V. I.

DEC 12 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

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11676

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rodgers Forge</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rodgers Forge</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>218 Dunkirk Road - 12</u>		STREET ADDRESS (If rural, give location) <u>218 Dunkirk Road - 12</u>	
3. NAME OF DECEASED (Type or Print) <u>JAMES</u> (First) <u>HOWARD</u> (Middle) <u>MEISER</u> (Last)		4. DATE OF DEATH (Month) <u>December</u> (Day) <u>5</u> (Year) <u>1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>July 31, 1880</u>
9. AGE last birthday <u>75</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>painter</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James H. Meiser</u>		14. MOTHER'S MAIDEN NAME <u>Anna Kramer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY No. <u>no</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Harold Buchanan 218 Dunkirk Rd.</u>		18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>163x</u> Immediate cause (a) <u>Cancer of the Lung</u> Antecedent cause(s) (b) _____ Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>none</u>			
19a. DATE OF OPERATION <u>none</u>		19b. MAJOR FINDINGS OF OPERATION <u>none</u>	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>none</u>		PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>none</u>		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on <u>Dec 4</u> , 19 <u>55</u> , and that death occurred at <u>12:45</u> a.m., from the causes and on the date stated above.			
SIGNATURE <u>A.S. Chaffaut, M.D.</u>		ADDRESS <u>6210 York Rd Baltimore, Md.</u>	
DATE SIGNED <u>Dec 5, 55</u>			
23. BURIAL, CREMATION REMOVAL (Specify) <u>burial</u>		DATE THEREOF <u>Dec. 7, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
DATE REC'D BY LOCAL REG. <u>Dec 7, 1955</u>		REGISTRAR'S SIGNATURE <u>H. Sander & Sons, Inc.</u>	
24. FUNERAL DIRECTOR <u>H. Sander & Sons, Inc.</u>		ADDRESS <u>Baltimore, Maryland</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



11677

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Ruxton</u>		<u>10 days</u>		TOWN <u>Baltimore</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sorensen Nursing Home</u>				STREET ADDRESS (If rural give location) <u>1412 N. Montford Ave</u>			
3. NAME OF DECEASED: (Type or Print)				4. DATE (Month) (Day) (Year)			
(First) <u>Alvena</u>		(Middle) <u>A</u>		(Last) <u>Meister</u>		DEATH: <u>Dec 20</u> 19 <u>55</u>	
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE MARRIED. WIDOWED, DIVORCED, (Specify): <u>Single</u>		8. DATE OF BIRTH: <u>Aug 22 1871</u>	
9. AGE last birthday: <u>84</u> yrs.		10. MONTHS <u>3</u> DAYS <u>28</u>		11. BIRTHPLACE (State or foreign country): <u>Baltimore Md</u>		12. CITIZEN OF WHAT COUNTRY?	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
13. FATHER'S NAME: <u>Julius Meister</u>				14. MOTHER'S MAIDEN NAME: <u>Marie Grober</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.		17. INFORMANT & ADDRESS: <u>Alvena A Meister 1412 N. Montford Av</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Toxaemia of gangrene</u>						I year	
DUE TO							
ANTECEDENT CAUSE (B) <u>Peripheral vascular disease</u>						3 years	
DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Ulceration skin, underlying tissues</u>						I year	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Myocarditis chronic. Myocardial hypertrophy</u>						5 years	
19A. DATE OF OPERATION: <u>none</u>				19B. MAJOR FINDINGS OF OPERATION: <u>no operation</u>			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR? <u>no injury</u>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: <u>no injury</u>		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		<u>no injury</u>	
22. I hereby certify that I attended the deceased from <u>12-13-</u> , 19 <u>55</u> to <u>12-30-</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12-17-</u> , 19 <u>55</u> , and that death occurred at <u>12.15M</u> , from the causes and on the date stated above.							
SIGNATURE <u>Jarvis Graham Manton</u>				P ADDRESS <u>M.D. 516 Cathedral Street</u>		DATE SIGNED <u>12-21-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Dec 23 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel</u>		LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE <u>[Signature]</u>		FUNERAL DIRECTOR <u>[Signature]</u>		ADDRESS <u>204 Ridgewood Ave</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11676

11678 CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		STATE <u>MARYLAND</u>		STATE <u>Maryland</u>		COUNTY <u>Prince George's</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Catonsville</u>		<u>1yr. 10 mos. 12 days</u>		TOWN <u>West Hyattsville</u>		<u>16-15-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove State Hospital</u>				STREET ADDRESS (If rural give location) <u>6206 20th Avenue</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>Annie</u> <u>Madden</u> <u>Mercer</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>December 14,</u> <u>19</u> <u>55</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>5-9-1881</u>		9. AGE last birthday <u>74</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Scotland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Patrick Corbett</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Corbett</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT & ADDRESS <u>Records Spring Grove State Hospital</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
1. IMMEDIATE CAUSE (A) <u>Congestive heart failure</u>						<u>3 months</u>	
2. ANTECEDENT CAUSE(S) DUE TO (B) <u>Fibrosis of myocardium due to infarction</u>						<u>1 year plus</u>	
3. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Arteriosclerotic cardiovascular disease</u>						<u>years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. PLACE (Home, farm, factory, of injury street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2-2-</u> 19 <u>54</u>, to <u>12-14-</u> 19 <u>55</u>, that I last saw the deceased alive on <u>12-14-</u> 19 <u>55</u>, and that death occurred at <u>12 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>C. Wachter</u>				ADDRESS (Street, city, town, state) <u>Spring Grove State Hospital</u> <u>M.D. Catonsville 28, Maryland</u>		DATE SIGNED <u>12/14/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>12/17/55</u>		NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u>		LOCATION (City, town, or county) (State) <u>Calmar Manor</u>	
24. REC'D BY REGISTRAR <u>U.E. Harry</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>Malley's Funeral Home</u> <u>3200 K. Island Ave., Mt. Rainier, Md.</u>			
DATE <u>12/14/55</u>							

5.2

11679

CERTIFICATE OF DEATH

Reg. Dist. No. 39

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u> <u>MARYLAND</u>				STATE <u>Maryland</u> COUNTY <u>Baltimore</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Parkville</u>				CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Parkville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>3514 Joppa Road</u>				STREET ADDRESS (If rural give location) <u>3514 Joppa Road</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>Mrs. Anna M. Miller</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Dec. 22nd 19 55</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>Oct. 2, 1886</u>		9. AGE last birthday <u>69</u> yrs.	IF UNDER 1 YEAR (Months) (Days) IF UNDER 24 HRS. (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Mr. Joseph Miller</u>				14. MOTHER'S MAIDEN NAME <u>Mary Ewers</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mr. Paul P. Miller, 3514 Joppa Road</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Cardiac failure</u>				<u>1 week</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>arteriosclerotic cardiovascular</u>				<u>18 Mo.</u>			
(C) <u>renal disease</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> 21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> 21f. HOW DID INJURY OCCUR?							
22. I hereby certify that I attended the deceased from <u>June 19 54</u> to <u>12/22</u>, 19 <u>55</u>, that I last saw the deceased alive on <u>12/20</u>, 19 <u>55</u>, and that death occurred at <u>8:30</u> P.M. from the causes and on the date stated above.							
SIGNATURE <u>Harold A. Grott, M.D.</u>				ADDRESS (Street, city, town, state) <u>8700 Harford Rd - Baltimore, Maryland</u>		DATE SIGNED <u>12/23/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Dec. 26, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial Park</u>		LOCATION (City, town, or county) <u>Baltimore, Maryland</u>	
24. REC'D BY REGISTRAR <u>55</u>		REGISTRAR'S SIGNATURE <u>Dr. A. M. Bacon</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		ADDRESS <u>5305 Harford Road #14</u>	
DATE							

BOOKEND W.A.

DEC 23 1955

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PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

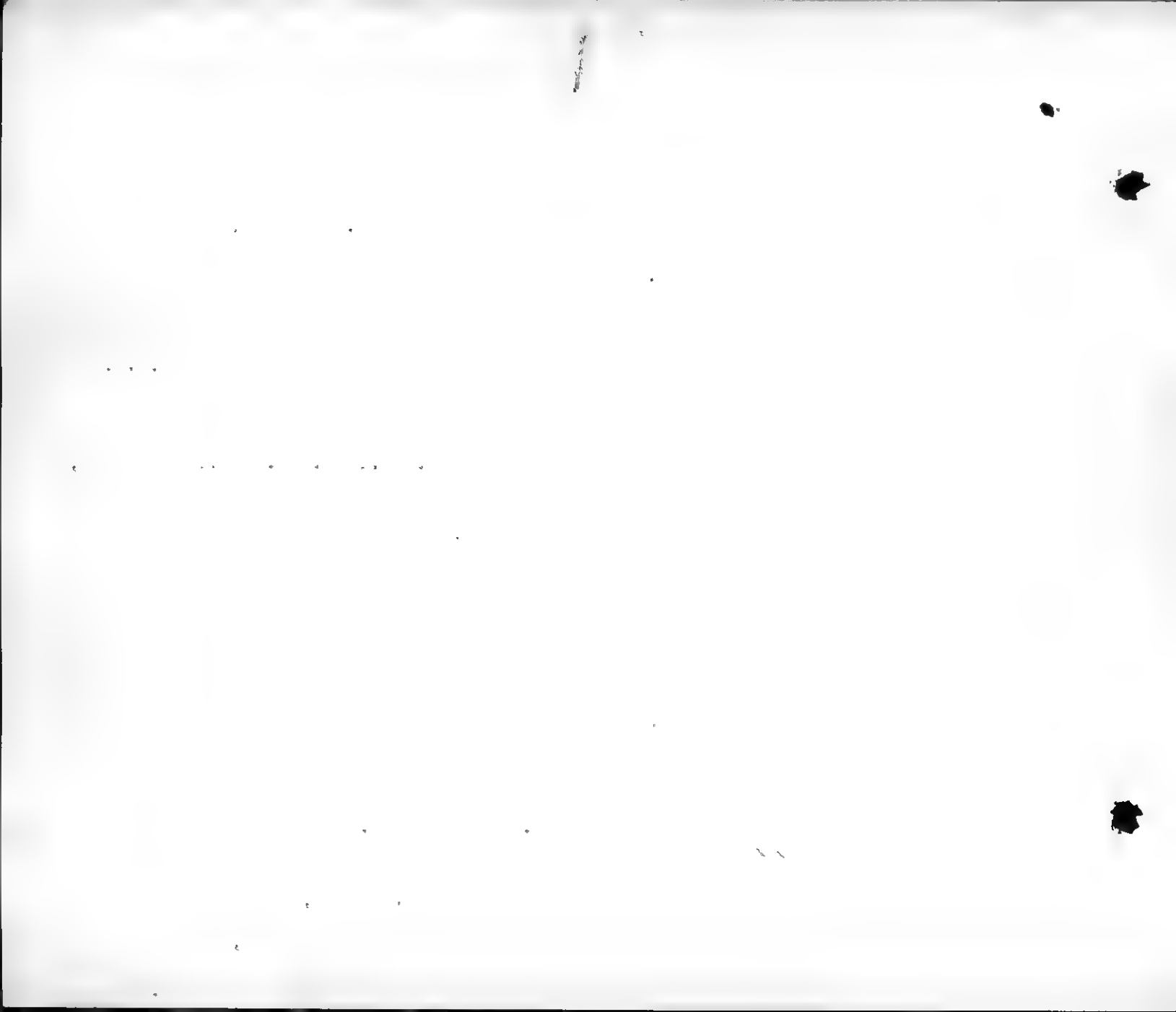
11678

11680

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Fort Howard</u>		LENGTH OF STAY (in this place) <u>1163 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location) <u>124 S. Mount St.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>RAYMOND J. MILLER</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>December 2 19 55</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>3-16-07</u>	9. AGE last birthday <u>48 yrs.</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Sheet Metal Worker</u>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Frank Miller</u>				14. MOTHER'S MAIDEN NAME: <u>Mary Gross</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes</u> <u>WW II</u>		16. SOCIAL SECURITY No. <u>215-09-4986</u>		17. INFORMANT & ADDRESS: <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>EMPHYEMA, PLEURAL, RIGHT</u>						<u>3 WEEKS</u>	
ANTECEDENT CAUSE (S) (B) <u>TUBERCULOSIS, PULMONARY, FAR ADVANCED</u>						<u>3 YEARS</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>BRONCHOPLEURAL FISTULA, RIGHT</u>						<u>3 WEEKS</u>	
19A. DATE OF OPERATION: <u>11/18/55</u> <u>11/28/55</u>		19B. MAJOR FINDINGS OF OPERATION <u>Right upper lobectomy-pulmonary tuberculosis</u> <u>Thoracoplasty, right-bronchopleural fistula</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>11/28/55</u> <u>11:00 PM</u>		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work					
22. I hereby certify that I attended the deceased from <u>Sept. 25</u> , 19 <u>52</u> to <u>Dec. 2</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Dec. 2</u> , 19 <u>55</u> , and that death occurred at <u>11:00 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>George Lerner</u>		ADDRESS <u>VAH Ft. Howard Md</u>		DATE SIGNED <u>12/3/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12/6/55</u>		NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>2-5-56</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>Hitzke Funeral Directors</u>			
				ADDRESS <u>Hollins & Gilmer St Balto. Md</u>			



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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 14 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-45 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11679

11681 CERTIFICATE OF DEATH

Reg. Dist. No. 35

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		STATE <u>Md.</u>		COUNTY <u>Baltimore</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural-White Hall</u>		LENGTH OF STAY (in this place) <u>35 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural-White Hall</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Old York Rd.</u>		STREET ADDRESS (If rural give location) <u>Old York Rd.</u>					
3. NAME OF DECEASED (Type or Print) <u>David Sylvester Moore</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>December 5, 1955</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, OR SEPARATED <u>Married</u>	8. DATE OF BIRTH <u>January 13, 1877</u>		9. AGE last birthday <u>78</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own farm</u>		11. BIRTHPLACE (State or foreign country) <u>Globe, North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>David Moore</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Dixon</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>-----</u>		17. INFORMANT & ADDRESS <u>Mrs. Carrie Moore, White Hall, Md.</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						16. MEDICAL CERTIFICATION	
<input checked="" type="checkbox"/> IMMEDIATE CAUSE (A) <u>Cardio-Vascular renal disease</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) _____							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) _____							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June</u> , 19 <u>50</u> , to <u>Dec. 5</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12/5/55</u> , 19 <u>55</u> , and that death occurred at <u>4:00 A.M.</u> on the causes and on the date stated above.							
SIGNATURE <u>D. M. France</u>				ADDRESS (Street, city, town, state) <u>Parleton, Ind.</u>		DATE SIGNED <u>12/6/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Dec 7, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>West Liberty Cem.</u>		LOCATION (City, town, or county) (State) <u>White Hall, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Charles J. Feltner</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>David Hartenstein</u>		ADDRESS <u>New Freedom, Pa.</u>	
DATE <u>12/10/55</u>							

RECEIVED

DEC 20 1955

BUREAU V. 3

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

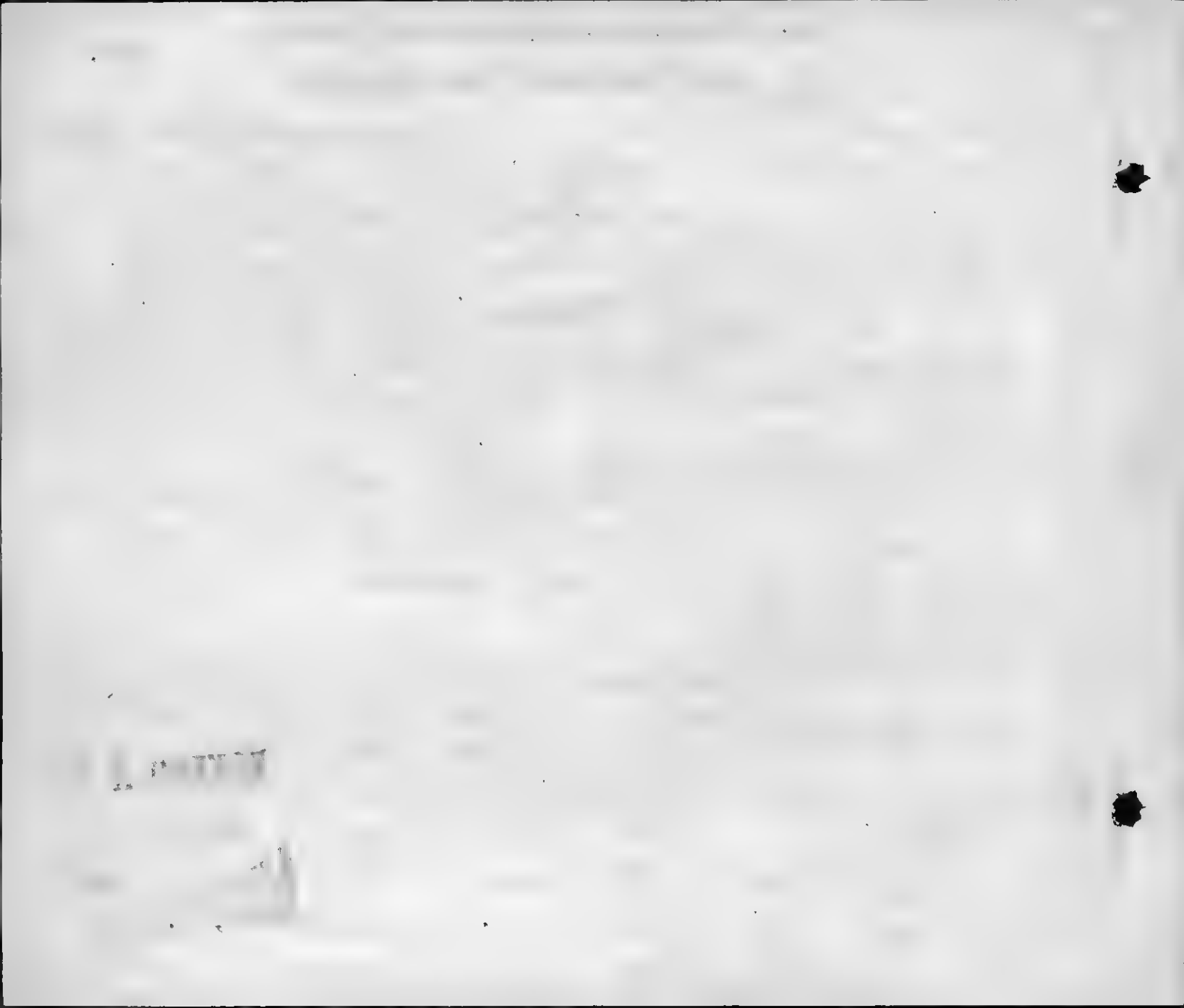
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11682

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		STATE <u>Md.</u> COUNTY <u>Balto.</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>Catonsville</u>		TOWN <u>Stoneleigh</u>		STREET ADDRESS		(If Rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove St. Hosp.</u>				STREET ADDRESS <u>809 Kingston Rd.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Clara</u> (Middle) <u>Katherine</u> (Last) <u>MORAN</u>				(Month) <u>Dec.</u> (Day) <u>19</u> (Year) <u>1955</u>			
5. SEX <u>F.</u>	6. COLOR OR <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>10. 18. 1887</u>	9. AGE last birthday <u>68</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Demonstrator</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry STEPHAN</u>				14. MOTHER'S MAIDEN NAME <u>Magdalena Kheifer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. <u>213-05-7217</u>		17. INFORMANT & ADDRESS <u>Stephen Moran, 809 Kingston Rd.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Pulmonary emboli</u>						<u>3 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertensive cardiovascular disease</u>						<u>unknown</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 13th</u> , 19 <u>55</u> , to <u>Dec. 19</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Dec. 19</u> , 19 <u>55</u> , and that death occurred at <u>11:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Hertmole J. Flisshmann M.D.</u>				DATE SIGNED <u>12.19.55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12/21/55</u>		NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cem.</u>		LOCATION (City, town, & county) (State) <u>Woodlawn, Md.</u>	
24. REC'D BY REGISTRAR <u>1955</u>		REGISTRAR'S SIGNATURE <u>T. E. Harrys</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Violeux & Sons - Baltimore</u>		ADDRESS	



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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 14 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-15 104

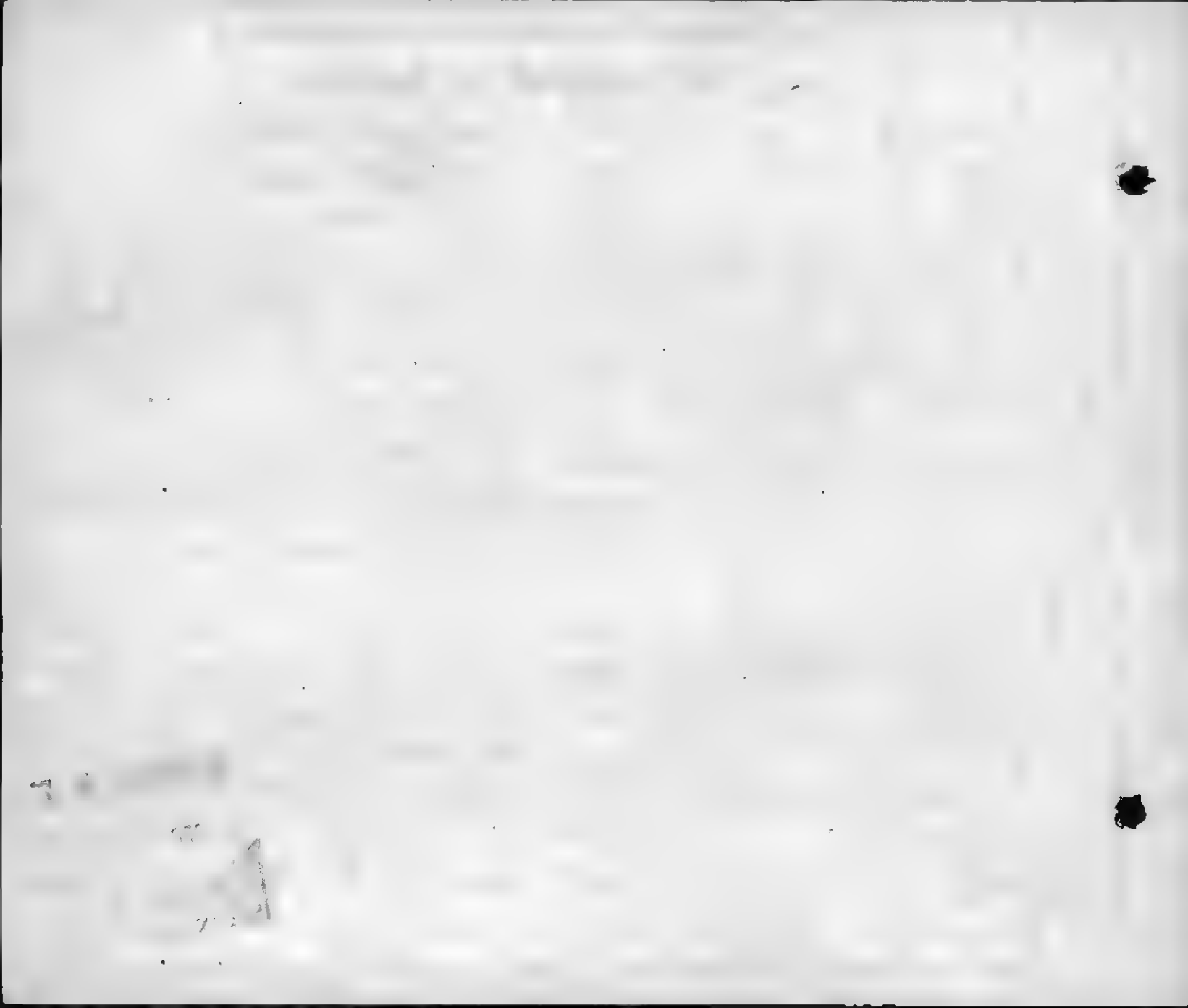
MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11683 CERTIFICATE OF DEATH

11681

Reg. Dist. No. 38

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		STATE <u>Maryland</u> COUNTY		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY OR TOWN <u>Ruxton</u>		LENGTH OF STAY (in this place) <u>6 days</u>		CITY OR TOWN <u>Baltimore</u>		STREET ADDRESS (If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sorrenson Nursing Home</u>		STREET ADDRESS <u>1305 N. Calvert Street</u>		STREET ADDRESS		STREET ADDRESS	
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>CHARLES REINHARDT MUELLER, SR.</u>				<u>Dec. 27, 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>male</u>	<u>white</u>	<u>widowed</u>	<u>Feb. 26, 1872</u>	<u>83</u> yrs.	<u>10</u> Months <u>1</u> Days	<u>1</u> Hours <u></u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Ret. Musician</u>		<u>Century Theatre</u>		<u>Richmond, Virginia</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Otto Mueller</u>				<u>Katherine Schaefer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>no</u>				<u>Charles R. Mueller, Jr., 614 Kingston</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
<u>440X</u> IMMEDIATE CAUSE (A) <u>Myocarditis with failure</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Myocardial hypertrophy</u>				<u>5 years</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Arteriosclerosis generalized</u>				<u>5 years</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Glomerular renal changes</u>				<u>3 years</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
<u>none</u>		<u>no operation</u>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
<input type="checkbox"/>		<u>none</u>		<u>no injury</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<u>no injury</u>		<u>M.</u>		<u>no injury</u>			
22. I hereby certify that I attended the deceased from <u>Dec. 21, 1955</u>, to <u>Dec. 27, 1955</u>, that I last saw the deceased alive on <u>Dec. 23, 1955</u>, and that death occurred at <u>1:45 P.M.</u> from the causes and on the date stated above.							
SIGNATURE				DATE SIGNED			
<u>J. Graham Martin</u> M.D.				<u>516 Cathedral Street 12-28-1955</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>burial</u>		<u>12/29/55</u>		<u>Moreland Park Cemetery</u>		<u>Parkville, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Dec. 29, 1955</u>		<u>Mabel Gray</u>		<u>Wm. Cooke Inc.</u>		<u>1217 St. Paul St.</u>	

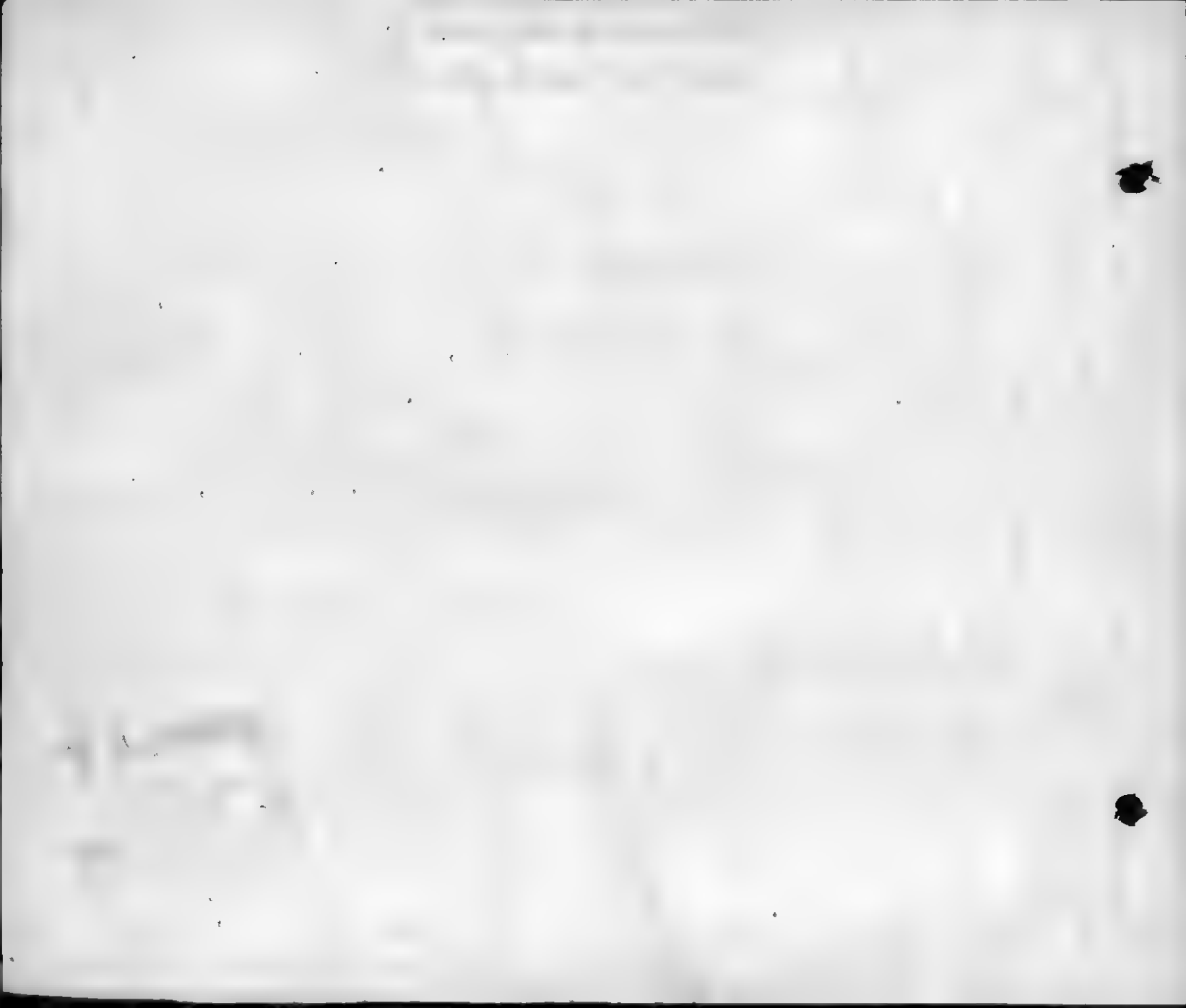


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INSTRUCTIONS
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.
VS AISC 1-55 10M

11684

CERTIFICATE OF DEATH

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MAYLAND		STATE <u>MD.</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Catonsville</u>		LENGTH OF STAY (In this place) <u>LIFE</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>23 Ridge Road</u>				STREET ADDRESS (If rural give location) <u>23 Ridge Road</u>			
3. NAME OF DECEASED (Type or Print) <u>Edna</u> (First) <u>Mueller</u> (Middle) <u></u> (Last)				4. DATE OF DEATH (Month) (Day) (Year) <u>Dec. 4, 1955</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Aug. 12, 1890</u>	
9. AGE last birthday <u>75</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H.W.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>	
13. FATHER'S NAME <u>Henry Schwalm</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Michael</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u></u>				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Charles A. Mueller, 23 Ridge Rd</u>	
18. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				16. MEDICAL CERTIFICATION			
<u>420.1</u> IMMEDIATE CAUSE (A) <u>CORONARY THROMBOSIS</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u>HYPER TENSIVE ARTERIO SCLEROTIC</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>CARDIO-VASCULAR DISEASE</u> <u>HYPODYNAMIC ARTERIES</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u></u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>M</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21i. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12/2</u>, 19<u>55</u>, to <u>12/4</u>, 19<u>55</u>, that I last saw the deceased alive on <u>12/4</u>, 19<u>55</u>, and that death occurred at <u>5:30 AM</u>, from the causes and on the date stated above.							
SIGNATURE <u>John H. [Signature]</u>		DATE THEREOF <u>Dec. 7/55</u>		PLACE OF CEMETERY OR CREMATORY <u>Serraine Park</u>		DATE SIGNED <u>12/6/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		24. REC'D BY REGISTRAR		25. FUNERAL DIRECTOR'S SIGNATURE <u>Harry A. Wietje</u>		ADDRESS <u>4101 Edmonson Ave.</u>	



11685

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND.	STATE <u>Maryland</u>	COUNTY <u>Baltimore</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR	
TOWN <u>Weltondale</u>		TOWN <u>Weltondale</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>16 Aintree Road</u>		STREET ADDRESS (If rural give location)	<u>16 Aintree Road</u>
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<u>Katherine A. Muir</u>		DATE OF DEATH: <u>12</u> <u>27</u> <u>19</u> <u>55</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>1/21/1873</u>
9. AGE last birthday: <u>82</u> yrs.		10. UNDER 1 YEAR: Months Days Hours Min.	11. BIRTHPLACE (State or foreign country): <u>Scotland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME: <u>John Alexander</u>	
14. MOTHER'S MAIDEN NAME: <u>Mary McGlean</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service): <u>No</u>	
16. SOCIAL SECURITY NO.: <u>None</u>		17. INFORMANT & ADDRESS: <u>Mr. Robert N. Francis-16 Aintree Road</u>	
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		10 yrs.	
IMMEDIATE CAUSE (A) <u>Hypertension cardiovascular renal disease</u>			
ANTECEDENT CAUSE (S):			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>Dec 26, 1955</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Dec 26, 1955</u> , to <u>Dec 27, 1955</u> , that I last saw the deceased alive on <u>Dec 27, 1955</u> , and that death occurred at <u>3:00 P.</u> M., from the causes and on the date stated above.			
SIGNATURE <u>Lloyd E. Saylor</u>		ADDRESS <u>M.D. 3902 Greenmount Ave.</u>	
DATE SIGNED <u>12/29/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12/30/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>		LOCATION (City, town, or county) (State) <u>Pikesville, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>12-29-55</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>	
24. FUNERAL DIRECTOR <u>Wm. J. [Signature]</u>		ADDRESS <u>Home - North & Pa Balto - 17 Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



CERTIFICATE OF DEATH

Reg. Dist. No.

Item 7, Film 190-12-55 et

1. PLACE OF DEATH:

COUNTY **BALTIMORE** MARYLAND
 CITY (If outside corporate limits, write RURAL and give nearest town) **GRACELAND PARK** LENGTH OF STAY (in this place) **28 YRS.**
 HOSPITAL OR INSTITUTION OR STREET ADDRESS **6994 RAILWAY AVE**

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE **MD.** COUNTY **BALTIMORE**
 CITY (If outside corporate limits, write RURAL and give nearest town) **GRACELAND PARK Dundalk**
 TOWN **Dundalk** (If rural, give location) **1 md.**
 STREET ADDRESS **6994 RAILWAY AVE**

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

4. DATE

(Month)

(Day)

(Year)

(Type or Print)

BRONISLAW**P.****MYSLINSKI**

OF DEATH:

DEC. 21.**1955**

5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH:

9. AGE last birthday:

IF UNDER 1 YEAR

IF UNDER 24 HRS.

MALE
WHITE

Married
JUNE 12 1927

68 yrs.
3 Months **9** Days **7** Hours **1** Min.

11. BIRTHPLACE (State or foreign country):
POLAND

12. CITIZEN OF WHAT COUNTRY:
U.S.A.

13. FATHER'S NAME:

KOSTEK. MYSLINSKI

14. MOTHER'S MAIDEN NAME:

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
 (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

STELLA MYSLINSKI 6994 RAILWAY AVE

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

420.1

Immediate cause

(a)

DUE TO

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b)

DUE TO

(c)

Coronary thrombosis**Myocarditis, chronic**

INTERVAL BETWEEN ONSET AND DEATH

10 months**3 years**

II. OTHER SIGNIFICANT CONDITIONS:

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION:

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)
 OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)
 OF INJURY

INJURY OCCURRED
 While at Not while
 M. work ☐ at work ☒

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Dec 20**, 19**55**, to **Dec 21**, 19**55**, that I last saw the deceased alive on **Dec 20**, 19**55**, and that death occurred at **7:25** a.m., from the causes and on the date stated above.

SIGNATURE

(DEGREE OR TITLE)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

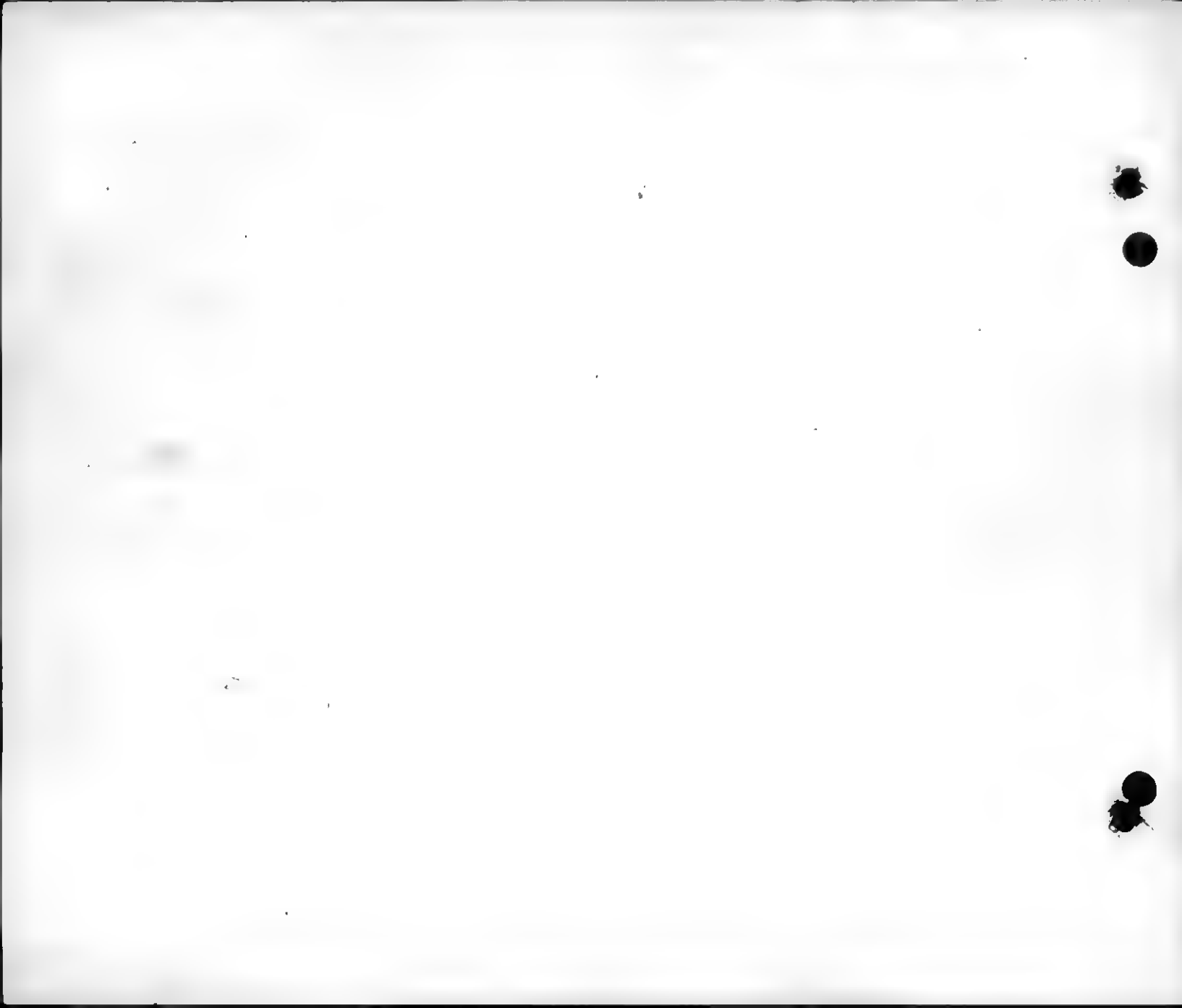
ADDRESS

22-55**DEC 24 1955 SACRED HEART OF MARY****TRAPPE ROAD****MD.****WENDELL J. LIPPEL 3125 Highland ave**

MARGIN RESERVED FOR BINDING

VS. A15 8-51

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



11687 CERTIFICATE OF DEATH

Reg. Dist. No.

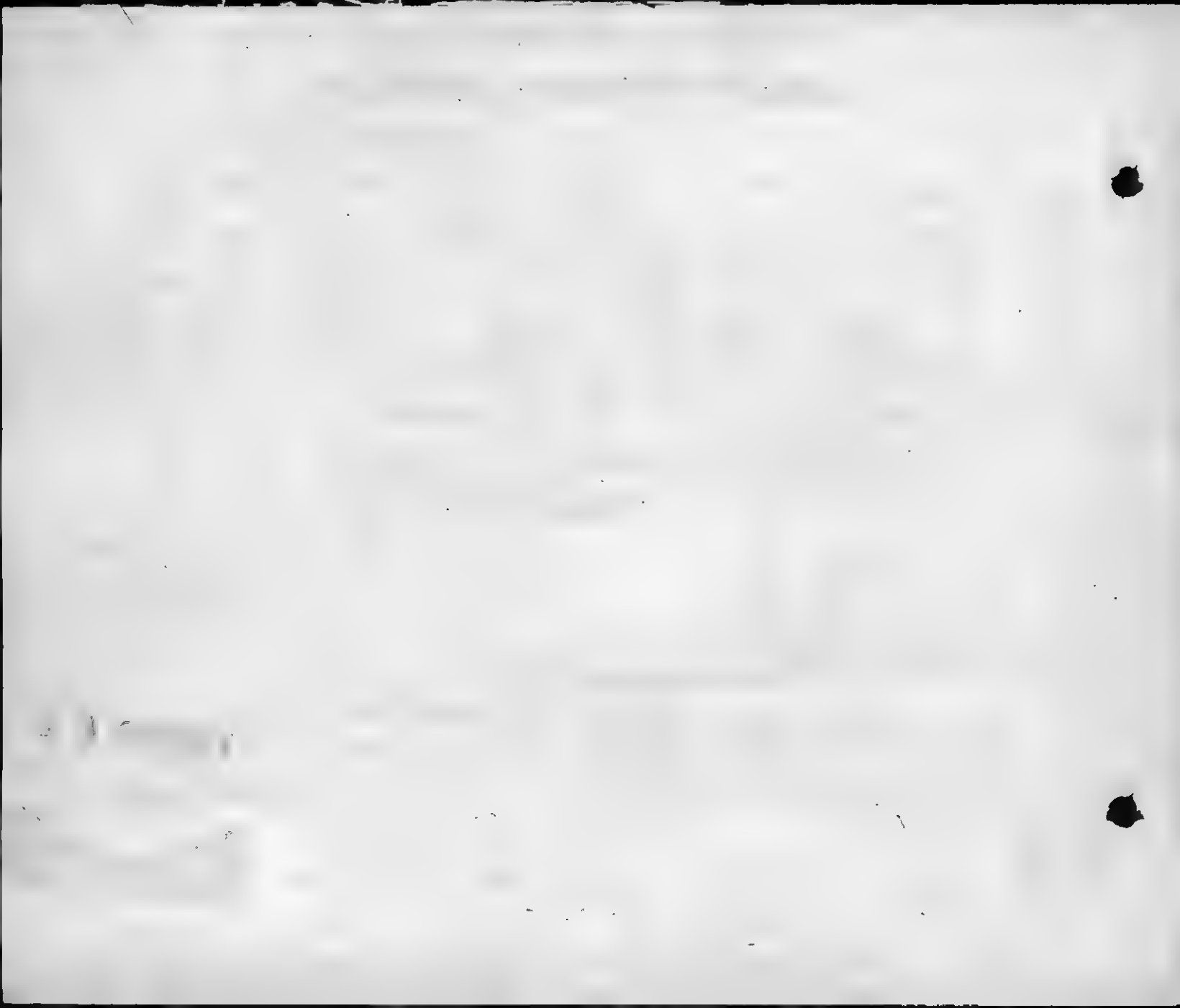
1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>BALTO.</u>	MARYLAND	STATE <u>MD</u>	COUNTY <u>BALTO.</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>SPARROWS POINT</u>	<u>38</u>	TOWN <u>SPARROWS POINT (19)</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>406 E ST.</u>		STREET ADDRESS (If rural give location) <u>406 E STREET</u>	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH (Month) (Day) (Year)	
<u>JAMES S. O'ROURKE, SR.</u>		<u>12-22-1953</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>26 DEC 1883</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WEIGHT MASTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RAILROAD</u>	9. AGE last birthday <u>71</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>CONN.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JAMES H. O'ROURKE</u>		14. MOTHER'S MAIDEN NAME <u>UNK -</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>705-10-9695</u>	
17. INFORMANT & ADDRESS <u>ADA W. O'ROURKE - SAME</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			18. MEDICAL CERTIFICATION
IMMEDIATE CAUSE (A) <u>Carcinoma of Lung</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 mos.</u>
ANTECEDENT CAUSE(S) DUE TO (B) _____			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) _____			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) _____	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____	
22. I hereby certify that I attended the deceased from <u>9/8, 1953</u> to <u>12/22, 1953</u> , that I last saw the deceased alive on <u>12/20, 1953</u> , and that death occurred at <u>1 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>DAVID OWENS, M.D.</u>		ADDRESS (Street, city, town, state) <u>M.D. 714 D ST. SPARROWS POINT MD.</u>	
DATE <u>12/28/55</u>		DATE SIGNED <u>12/23/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>	DATE THEREOF <u>12/24/55</u>	NAME OF CEMETERY OR CREMATORY <u>CHURCH LAWN</u>	LOCATION (City, town, or county) <u>BALTO. Co., Md.</u>
24. REC'D BY REGISTRAR <u>DAVID L. FARKER</u>	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Joseph Bradley</u>	ADDRESS <u>1401</u>

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The ☒ requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M



11638

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Balto</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Balto Parkville</u>	LENGTH OF STAY (in this place) <u>Life</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Balto</u>	<u>14</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>9304 Harford Rd.</u>		STREET ADDRESS (If rural give location) <u>9304 Harford Rd.</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <u>Katherine</u>	(Middle) <u>-</u>	(Last) <u>Off.</u>	(Month) <u>Dec</u> (Day) <u>14</u> (Year) <u>1955</u>
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Mar.</u>	8. DATE OF BIRTH: <u>Dec 2, 1874</u>
9. AGE last birthday: <u>81</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS.	
11. BIRTHPLACE (State or foreign country): <u>Frankfort, England</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>Phillip Spindler</u>		14. MOTHER'S MAIDEN NAME: <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY No.: <u>---</u>	
17. INFORMANT & ADDRESS: <u>Husband, same</u>			

18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	Interval Between Onset And Death
Immediate cause (a) <u>Myocardial Insufficiency</u>	<u>14 Mo.</u>
Antecedent causes (s) (b) <u>Senility with Arteriosclerosis</u>	
(c)	

11. OTHER SIGNIFICANT CONDITIONS		19. DATE OF OPERATION: <u>No</u>		20. AUTOPSY? <u>No</u>	
Conditions contributing to the death but not related to the disease or condition causing death.		21. MAJOR FINDINGS OF OPERATION			
21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>m.</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	HOW DID INJURY OCCUR?			

22. I hereby certify that I attended the deceased from <u>Sept 1953</u> , to <u>Dec 14, 1955</u> , that I last saw the deceased alive on <u>Dec 14, 1955</u> , and that death occurred at <u>9:00 PM</u> , from the causes and on the date stated above.	
SIGNATURE <u>A. T. Heemann</u>	DATE SIGNED <u>12/14/55</u>
23. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	DATE THEREOF <u>12/17/55</u>
NAME OF CEMETERY OR CREMATORY <u>PARKWOOD</u>	LOCATION (City, town, or county) (State) <u>BALTO, Md.</u>
DATE REC'D BY LOCAL REGISTRAR <u>12-16-55</u>	REGISTRAR'S SIGNATURE <u>A. T. Heemann</u>
24. FUNERAL DIRECTOR <u>PAUL A. HEEMANN</u>	
ADDRESS <u>6067 HARFORD Rd.</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

For HARVEY 154
CARL F. HERRMAN

CERTIFICATE OF DEATH

Reg. Dist. No. 30

11689

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Baltimore</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Catonsville</u>	LENGTH OF STAY (in this place) <u>3 1/2 yrs</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>620 Plymouth Rd.</u>		STREET ADDRESS (If rural, give location) <u>620 Plymouth Rd.</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE OF DEATH: (Month) (Day) (Year)	
<u>GEORGE THEODORE W. OTTO</u>		<u>Dec 31 1955</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH: <u>May 28 1877</u>
			9. AGE last birthday: <u>78</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B+O.R.R.</u>	11. BIRTHPLACE (State or foreign country): <u>Baltimore Md.</u>
12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME: <u>Unknown</u>		14. MOTHER'S MAIDEN NAME: <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>7</u>		16. SOCIAL SECURITY No.: <u>—</u>	
		17. INFORMANT & ADDRESS: <u>Harriet E. Otto - 620 Plymouth Rd. 29</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			
Immediate cause (a) <u>Cerebro-vascular accident</u>			<u>36 hrs.</u>
DUE TO			
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last			
(c)			
II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. <u>PARKINSONISM</u>			<u>8 yrs</u>
19a. DATE OF OPERATION: <u>0</u>		19b. MAJOR FINDINGS OF OPERATION:	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>12/30</u> , 19 <u>55</u> , to <u>12/31</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12/30</u> , 19 <u>55</u> , and that death occurred at <u>7:52 A.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>J. J. Wilson</u>		DATE SIGNED <u>12/31/55</u>	
(DEGREE OR TITLE)		ADDRESS <u>M.D. 6014 Edmondson Ave.</u>	
23. BURIAL, CREMATION REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>Jan 3-1956</u>	NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>
LOCATION (City, town, or county) <u>Baltimore Co. Md.</u>			
DATE REC'D BY LOCAL REG. <u>1-2-56</u>		24. FUNERAL DIRECTOR <u>John H. Geifel 5311 Edmondson Ave</u>	
REGISTRAR'S SIGNATURE <u>V. E. Harvey</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

JAN 4

1951

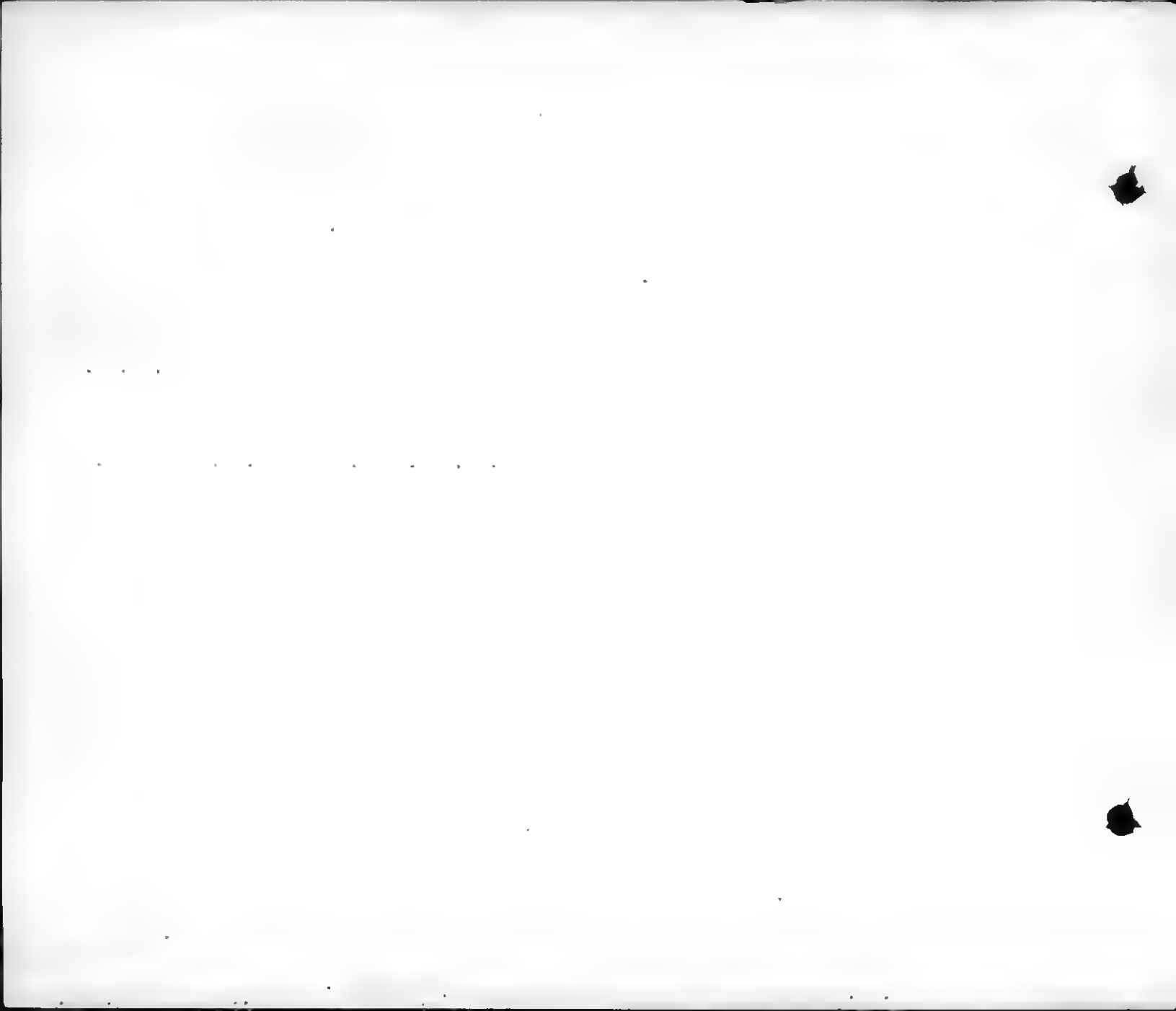
11690 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY BALTIMORE	MARYLAND	STATE MARYLAND	COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) X TOWN FORT HOWARD	LENGTH OF STAY (in this place) 4 DAYS	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN BALTIMORE	
HOSPITAL OR INSTITUTION OR STREET ADDRESS VETERANS ADMINISTRATION HOSPITAL		STREET ADDRESS (If rural give location) 1355 N. STRICKER STREET	
3. NAME OF DECEASED: (First) (Middle) (Last) CLYDE H. OWEN		4. DATE (Month) (Day) (Year) OF DEATH: DECEMBER 12 1955	
5. SEX: MALE	6. COLOR OR RACE: COLORADO	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): MARRIED	8. DATE OF BIRTH: 6-2-07
9. AGE last birthday 48 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): BARBER		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): SOUTH BOSTON, VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME: JACOB OWEN		14. MOTHER'S MAIDEN NAME: MARY SMITH	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) YES WW II		16. SOCIAL SECURITY NO. 212-07-0956	
17. INFORMANT & ADDRESS: CLINGREC., VET. ADM. HOSP. FT. HOWARD, MD.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
237x IMMEDIATE CAUSE (A) BRAIN TUMOR RIGHT HEMISPHERE		UNKNOWN	
ANTECEDENT CAUSE (B) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. SICKLE CELL TRAIT		UNKNOWN	
19A. DATE OF OPERATION: C	19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) INJURY OCCUR?	(County) (State)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY VA M.	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from DEC. 8, 1955 , to DEC. 12, 1955 , that I last saw the deceased alive on DEC. 12, 1955 and that death occurred at 2:15 P. from the causes and on the date stated above.			
SIGNATURE H. H. SMITH		DATE SIGNED 12/13/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) REMOVAL		DATE THEREOF 12/13/55	NAME OF CEMETERY OR CREMATORY Zion Hill Cemetery
LOCATION (City, town, or county) (State) Virgilina, Va.			
DATE REC'D BY LOCAL REGISTRAR		24. FUNERAL DIRECTOR ADDRESS	
REGISTERAR'S SIGNATURE		Charles R. Law Funeral Home	
SHIPPED TO: H. H. SMITH FUNERAL HOME, Virgilina, Va. 802 Madison Ave., Baltimore, Md.			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 11689

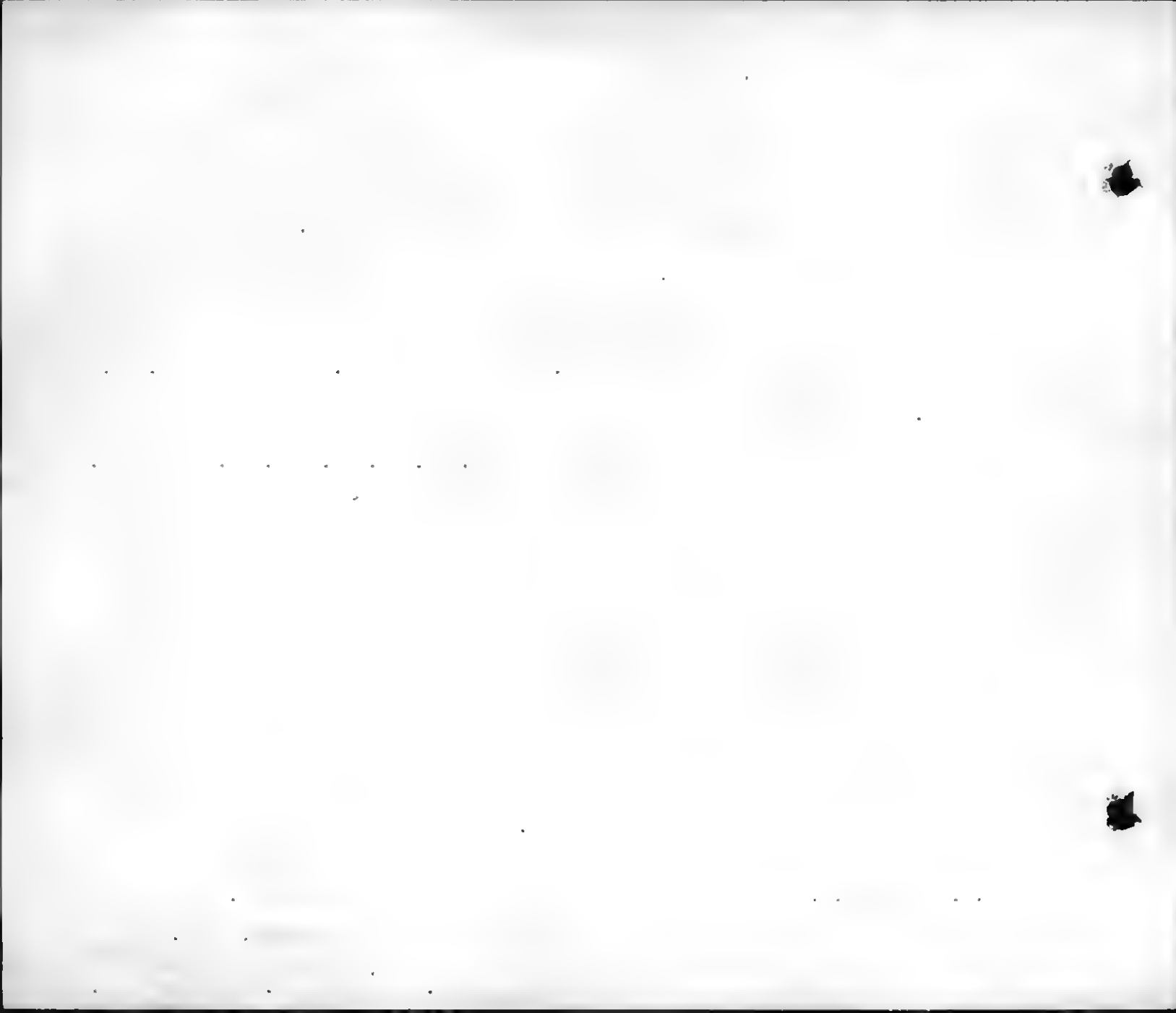
Item 1, Film 190 12-18-55 et

11691

CERTIFICATE OF DEATH

Reg. Dist. No. 11689

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>			
TOWN <u>Fort Howard</u>		<u>79 80 Days</u>		STREET ADDRESS (If rural give location)			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>		1708 W. Baltimore Street					
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>MAURICE J. PARKER</u>				<u>December 11 1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>10/23/04</u>	<u>51</u> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Truck Driver</u>		<u>Shirks Motor Co.</u>		<u>Palmyra, Tenn.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Alex J. Parker</u>				<u>Ella Hughes</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
<u>Yes</u>		<u>WW-II</u>		<u>Clin. Rec. Vet. Adm. Hosp., Ft. Howard, Md.</u>			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>METASTATIC CARCINOMA TO BRAIN</u>						<u>2 Years</u>	
ANTECEDENT CAUSE (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
<u>1/6/13/55</u>		<u>Excision of Metastatic Mucoid Carcinoma</u>					
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Sept. 23 1955, to Dec. 11 1955, and that death occurred at 7:45 AM, from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
<u>W.C. DUDLEY, M.D.</u>		<u>Fort Howard, Md.</u>		<u>12/11/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Dec. 15, 1955</u>		<u>Palmyra Cemetery</u>		<u>Palmyra, Tenn.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>12/15/55</u>		<u>[Signature]</u>		<u>Frederick A. Cole Funeral Home</u>		<u>1913 W. Baltimore St. Baltimore, Md.</u>	



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A19C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

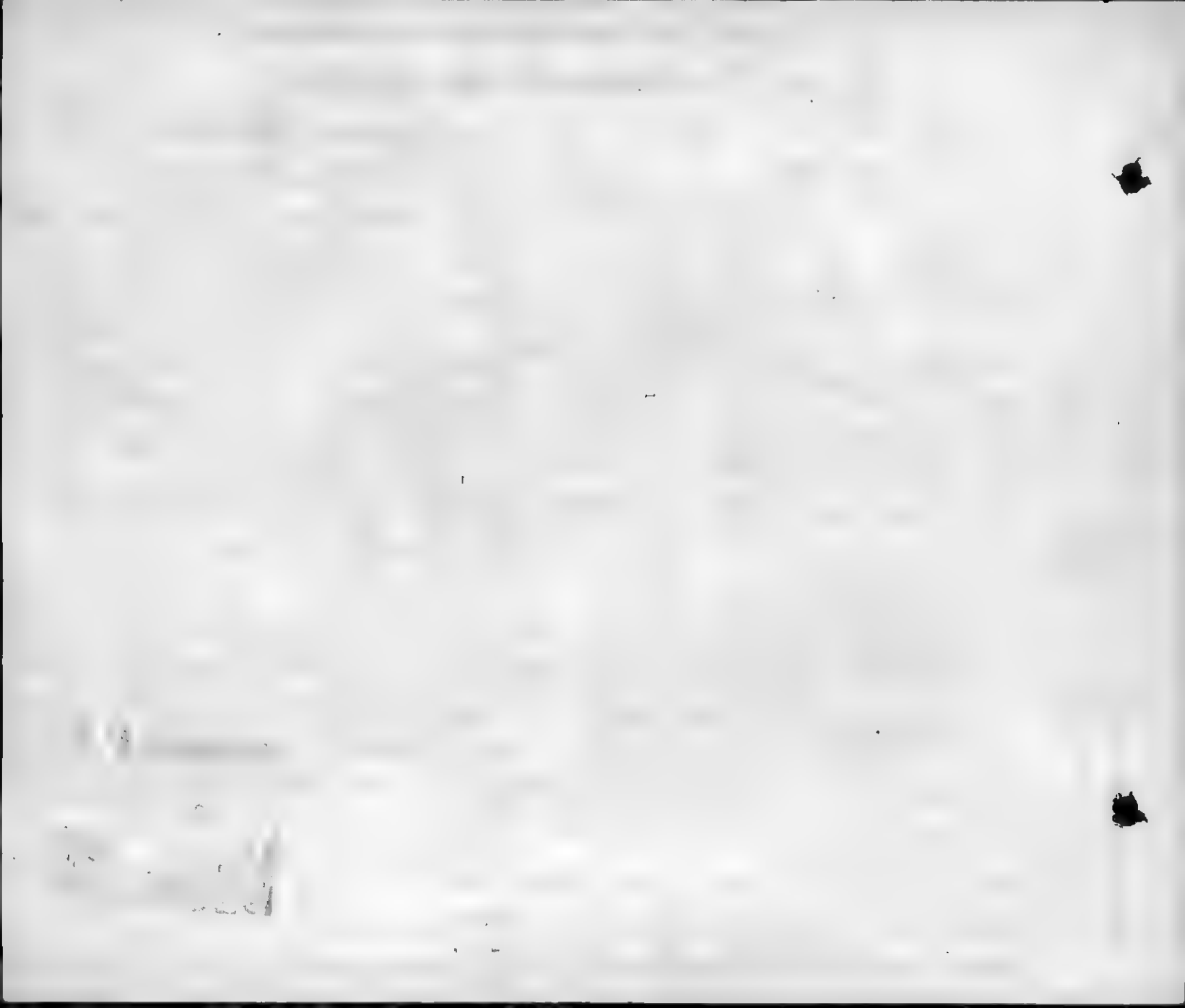
11690

11692

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Reisterstown</u>		LENGTH OF STAY (In this place) <u>60 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Reisterstown</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>510 Main Street</u>				STREET ADDRESS (If rural give location) <u>510 Main Street</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Annie Belle Parsons</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Dec 24 1955</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>April 12 1877</u>	9. AGE last birthday <u>78</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jarrett Tracey</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Luce</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>O'Dell Peltzer Reisterstown Md</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Adenocarcinoma Rt. Kidney</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 mo.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) _____							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) _____							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Adenocarcinoma</u>							
19a. DATE OF OPERATION <u>Feb 25 '55</u>		19b. MAJOR FINDINGS OF OPERATION <u>Adenocarcinoma Rt. Kidney</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>None</u>		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>None</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>None</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>None</u>		21e. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>None</u>			
22. I hereby certify that I attended the deceased from <u>7-23</u> , 19 <u>54</u> , to <u>12-24</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12-24</u> , 19 <u>55</u> , and that death occurred at <u>8 P</u> M, from the causes and on the date stated above.							
SIGNATURE <u>L. Z. Caples</u>		DATE THEREOF <u>Dec 27 1955</u>		NAME OF CEMETERY OR CREMATORY <u>St Paul Cemetery</u>		LOCATION (City, town, or county) (State) <u>Arcadia Md</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		24. REC'D BY REGISTRAR <u>Mary B. Zline</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm Berryman & Son</u>		ADDRESS <u>Reisterstown</u>	



11691

11693

CERTIFICATE OF DEATH

Reg. Dist. No. 37

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
<u>Rural Sparks</u>		<u>6 yrs.</u>		<u>Rural Sparks</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				ADDRESS (If rural give location)			
<u>Belfast Rd.</u>				<u>Belfast Rd.</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Minnie Ida Pearce</u>				<u>December 25 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Widow</u>	<u>October 17 1871</u>	<u>84</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife Own Home</u>				<u>Bentley Springs Md.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Unknown</u>				<u>Zane Wilson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT'S ADDRESS	
<u>No</u>						<u>Herbert Pearce - Sparks Md.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
444 * IMMEDIATE CAUSE (A) <u>Cardio-Vascular and diu</u>						<u>1 week</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST. (C)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
<u>0</u>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1945</u> to <u>12/25</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12/25/55</u> , 19 <u>55</u> , and that death occurred at <u>10:00 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>C. M. France</u>				ADDRESS (Street, city, town, state) <u>Parkton Md.</u>		DATE SIGNED <u>12/26/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Dec 28 1955</u>		<u>Vernon Cemetery</u>		<u>White Hall, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>29 Dec 55</u>		<u>June Annistead H. R. R.</u>		<u>Jacob Hartenstein</u>		<u>New Freedom, Pa.</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

U.S. AIR FORCE

2

10/1/54

11694 CERTIFICATE OF DEATH

Reg. Dist. No. - 1

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Baltimore</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>RURAL - ROCKDALE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>8227 LIBERTY RD - BALTO, MD.</u>		<u>76</u>		STREET ADDRESS (If rural give location) <u>8227 LIBERTY RD. - BALTO. 7, MD.</u>			
3. NAME OF DECEASED: (Type or Print)		(First) (Middle) (Last)		4. DATE (Month) (Day) (Year)			
<u>WALTER JOHN PIERPONT</u>				<u>12 / 22 1958</u>			
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): <u>MARRIED</u>	8. DATE OF BIRTH: <u>Dec. 28/1898</u>	9. AGE last birthday: <u>76</u> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>FARMER</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>FARMER</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>JOSEPH PIERPONT</u>				14. MOTHER'S MAIDEN NAME: <u>ELIZABETH MELLOR</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>NO</u>		16. SOCIAL SECURITY NO. <u>214-22-0119</u>		17. INFORMANT & ADDRESS: <u>WIFE - ELVA PIERPONT</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) <u>LYMPHOMA & CEREBRAL METASTASES</u>		<u>8 MONTHS</u>
ANTECEDENT CAUSE (B)		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		
(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH? (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb. 26, 1958 to Dec. 22, 1958, that I last saw the deceased alive on 12/20, 1958, and that death occurred at 10:15 PM, from the causes and on the date stated above.

SIGNATURE <u>Edwin E. Pierpont</u>	ADDRESS <u>8227 LIBERTY RD, BALTO, MD</u>	DATE SIGNED <u>12/23/58</u>
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>	DATE THEREOF <u>Dec 24 1958</u>	NAME OF CEMETERY OR CREMATORY <u>Mount Carmel Cemetery</u>
LOCATION (City, town, or county) (State) <u>Harwood, Baltimore Co, MD</u>		
DATE REC'D BY LOCAL REGISTRAR <u>12-23-58</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	24. FUNERAL DIRECTOR <u>[Signature]</u>
		ADDRESS <u>4511 Liberty Heights Ave</u>

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1

INSTRUCTIONS

THE ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11693

11695 CERTIFICATE OF DEATH

Reg. Dist. No. 42

1. PLACE OF DEATH COUNTY <u>BALTIMORE</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>GLENARTNEY</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>BOX 100 BALTO-27-MD.</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD.</u> COUNTY <u>BALTO</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>GLENARTNEY</u> STREET ADDRESS (If rural give location) <u>BOX 100- BALTO-27-MD.</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>SULLIVAN</u> <u>PITTS JR.</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>12-18-55</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>FEB. 23, 1876</u>	9. AGE last birthday <u>79</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS. Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>INS. EXECUTIVE</u>		11. BIRTHPLACE (State or foreign country) <u>BALTO. MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>SULLIVAN PITTS SR.</u>				14. MOTHER'S MAIDEN NAME <u>ELLEN LLOYD GOLDSBOROUGH</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>MRS. J. M. F. BERGLAND 229 LAMBETH RD</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Acute Coronary occlusion</u>				<u>10 min</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chor Myocarditis</u>				<u>6 wks</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Scurvy</u>							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct 27, 1953</u> , to <u>Dec 18, 1953</u> , that I last saw the deceased alive on <u>Dec 17, 1953</u> , and that death occurred at <u>7:10 A.M.</u> from the causes and on the date stated above. <u>12/19/53</u> SIGNATURE <u>B. B. Brumbaugh</u> ADDRESS (Street, city, town, state) <u>5709 Main St Edmdge 27 and MD.</u> DATE SIGNED							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>12-20-55</u>		NAME OF CEMETERY OR CREMATORY <u>GREENMOUNT CEM.</u>		LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>	
24. REC'D BY REGISTRAR DATE <u>Dec. 19, 1955</u>		REGISTRAR'S SIGNATURE <u>Dr. Geo. J. M. Luffey</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Henry D. Jenkins & Sons Co</u>		ADDRESS <u>4905 PORT RD.</u>	

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INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11696 CERTIFICATE OF DEATH

11694

Reg. Dist. No. 37

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Ba It.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Cockeysville</u>		<u>7 years.</u>		TOWN <u>Cockeysville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Ba It. Co. Home</u>				STREET ADDRESS (If rural give location) <u>York Road.</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>Gentry DE POPE</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Dec. 2 1955</u>			
5. SEX <u>FEMALE WHITE</u>		6. COLOR OR RACE <u>WHITE</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>SINGLE</u>		8. DATE OF BIRTH <u>April 25, 1877</u>	
9. AGE last birthday <u>77</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dressmaker</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>	
13. FATHER'S NAME <u>Lewis E. Pope</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Thompson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>NEEDHA. NICHILDA POPE - 622 BEAVER ST</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
491X IMMEDIATE CAUSE (A) <u>Broncho pneumonia</u>						<u>3 days</u>	
ANTECEDENT CAUSE(S) (B) <u>Arteriosclerosis; Arthritis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (C) <u>Arteriosclerosis; Arthritis</u>						<u>years.</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. PLACE (Home, farm, factory, of injury street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1/8</u> , 19 <u>49</u> , to <u>12/2</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Dec. 12</u> , 19 <u>55</u> , and that death occurred at <u>11:30 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Elizabeth B. Sherrill M.D.</u>				ADDRESS (Street, city, town, state) <u>Cockeysville, Maryland</u>		DATE SIGNED <u>12/3/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		DATE THEREOF <u>12/3/1955</u>		NAME OF CEMETERY OR CREMATORY <u>J. H. Black Funeral Home</u>		LOCATION (City, town, or county) (State) <u>BRISTOL, PA.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>W. J. Philcoat</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John Harris</u>		ADDRESS <u>Ann. Tolson, Md.</u>	
DATE <u>12/3/55</u>							

22

FEARLESS WHITE STONE APRIL 22, 1952
GENTLY DE
POPE

WILKINSON - 100 BEVER ST
BENNY

12/3/52 Mr. J. H. H. H.

11697

CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY BALTIMORE		MARYLAND		STATE MARYLAND		COUNTY BALTO.	
CITY (If outside corporate limits, write RURAL and give nearest town) RURAL - ROCKDALE		LENGTH OF STAY (in this place) 3 YEARS		CITY (If outside corporate limits, write RURAL and give nearest town) RURUR - 8316 LIBERTY RD		OR TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 8316 LIBERTY RD				STREET ADDRESS (If rural give location) 8316 LIBERTY RD - ROCKDALE			
3. NAME OF DECEASED: (First) ANNA (Middle) - (Last) POPIEN				4. DATE OF DEATH: (Month) 12 (Day) 23 (Year) 1955			
5. SEX: F	6. COLOR OR RACE: W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOWED	8. DATE OF BIRTH: 8/20/1889	9. AGE last birthday: 66 yrs.		10. IF UNDER 1 YEAR: Months 12 Days 23 Hours 19 Min.	
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY: HOUSEWIFE		11. BIRTHPLACE (State or foreign country): POLAND	
12. CITIZEN OF WHAT COUNTRY? POLAND ✓				13. FATHER'S NAME: unknown			
14. MOTHER'S MAIDEN NAME: unknown				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) 3 NO (If Yes, give war or dates of service)			
16. SOCIAL SECURITY No.: 196-09-8462D				17. INFORMANT & ADDRESS: 8316 Liberty Rd, SON - ALEXANDER POPIEN			

18. MEDICAL CERTIFICATION		Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) CORONARY THROMBOSIS		2 WEEKS
Antecedent causes (s) (b) HYPERTENSIVE CARDIOVASCULAR DISEASE		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c)		

11. OTHER SIGNIFICANT CONDITIONS		20. AUTOPSY ?	
Conditions contributing to the death but not related to the disease or condition causing death.		Yes <input type="checkbox"/> No <input type="checkbox"/>	
19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION		
21. ACCIDENT (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY) (STATE)
SUICIDE	HOMICIDE		
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	HOW DID INJURY OCCUR ?	

22. I hereby certify that I attended the deceased from **DEC 19, 1955**, to **DEC 23, 1955**, that I last saw the deceased alive on **DEC 22, 1955**, and that death occurred at **2:00 PM**, from the causes and on the date stated above.

SIGNATURE **Edwin J. Thompson M.D.** (Degree or title) ADDRESS **8204 LIBERTY RD BALTO, MD. 12/23/55** DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Removal - Burial	8/27/55	Hyde Park	Scranton, Pa.	
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
DEC 24 1955	H. J. [Signature]	Wm. J. Lickens & Sons - Balto	17, Md.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

BOOKED V. S.

DEC

1971

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

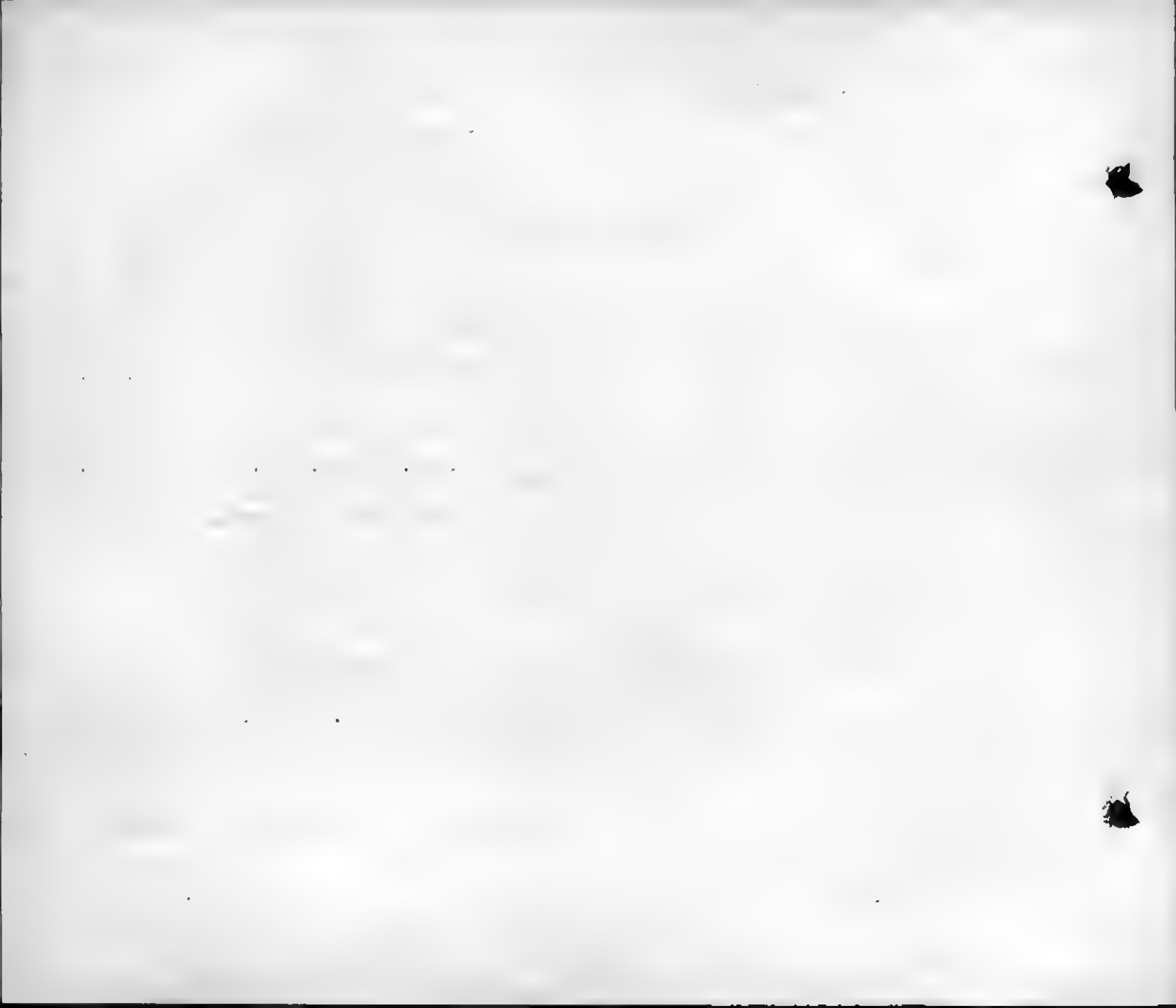
Items 8 & 9: Film G190

CERTIFICATE OF DEATH

Reg. Dist. No.

11696

1. PLACE OF DEATH: 11698		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Baltimore MARYLAND		STATE Maryland COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) Fort Howard		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Veterans Administration Hospital		STREET ADDRESS (If rural give location) 5526 Hilltop Avenue	
3. NAME OF DECEASED: (First) (Middle) (Last) THOMAS F. POTOCKI		4. DATE (Month) (Day) (Year) OF DEATH: December 28 1955	
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH: 12/9/1887
9. AGE last birthday: 68 yrs.		10. AGE last birthday: 68 yrs.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stock Clerk		10B. KIND OF BUSINESS OR INDUSTRY: Supply Company	
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Stanislaus Potocki		14. MOTHER'S MAIDEN NAME: Veronica Decuski	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) Yes WW-I		16. SOCIAL SECURITY NO. 216 01 3428	
17. INFORMANT & ADDRESS: Clin. Rec. Vet. Adm. Hosp., Ft. Howard, Md.			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) METASTATIC CARCINOMA OF THE RIB, PRIMARY		4 1/2 Months	
ANTECEDENT CAUSE (B) (A) SITE UNKNOWN			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. 002x			
DUE TO TRANSITIONAL SQUAMOUS CELL CARCINOMA			
DUE TO (C) PULMONARY TUBERCULOSIS, ACTIVE			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: 1/8/18/55		19B. MAJOR FINDINGS OF OPERATION Biopsy, right 9th rib	
19C. Metastatic transitional squamous cell Ca. in rib.		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY VA		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from June 2, 1955, to Dec. 28, 1955, and that death occurred at 3:47 PM, from the causes and on the date stated above.			
SIGNATURE Abraham A. Polachek, M.D.		ADDRESS VAH, Fort Howard, Md.	
DATE SIGNED 12/30/55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery	
DATE THEREOF 12/30/55		LOCATION (City, town, or county) (State) Baltimore, Maryland	
DATE REC'D BY LOCAL REGISTRAR 12/27/55		REGISTRAR'S SIGNATURE H. W. Hedrick	
24. FUNERAL DIRECTOR Mabel Leimbach Funeral Home		ADDRESS 525 Lyndhurst Ave. Baltimore, Maryland	



11699 CERTIFICATE OF DEATH

Reg. Dist. No. 35

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Parkton</u>	LENGTH OF STAY (In this place) <u>20 yrs.</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Parkton</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>—</u>		STREET ADDRESS (If rural give location) <u>—</u>	
3. NAME OF (First) (Middle) (Last) <u>James H. Pyle</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>December 14 1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>April 2 1895</u>
9. AGE last birthday <u>60</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Conductor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Ira Pyle</u>		14. MOTHER'S MAIDEN NAME <u>Daisy Atkinson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT & ADDRESS <u>Mrs. Joseph S. Bellinger, Parkton, Md.</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		15. MEDICAL CERTIFICATION	
420.0 IMMEDIATE CAUSE (A) <u>Congestive heart failure</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Indef.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic heart disease.</u>		<u>Indef.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>7/14</u>, 19<u>54</u>, to <u>12/13</u>, 19<u>55</u>, that I last saw the deceased alive on <u>12/13</u>, 19<u>55</u>, and that death occurred at <u>10:00 A.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Robert E. May</u> M.D. <u>1200 Woodbourne Av. Baltimore 12/16/55</u>		ADDRESS (Street, city, town, state) DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Dec 17/1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Wiscup Cemetery</u>		LOCATION (City, town, or county) <u>White Hall Balto Co., Md.</u>	
24. REC'D BY REGISTRAR <u>—</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Jacob Kantenstein</u>	
DATE <u>12/16/55</u>		ADDRESS <u>New Freedom, Pa.</u>	

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M



11700

11698

Reg. Dist.

No. 211

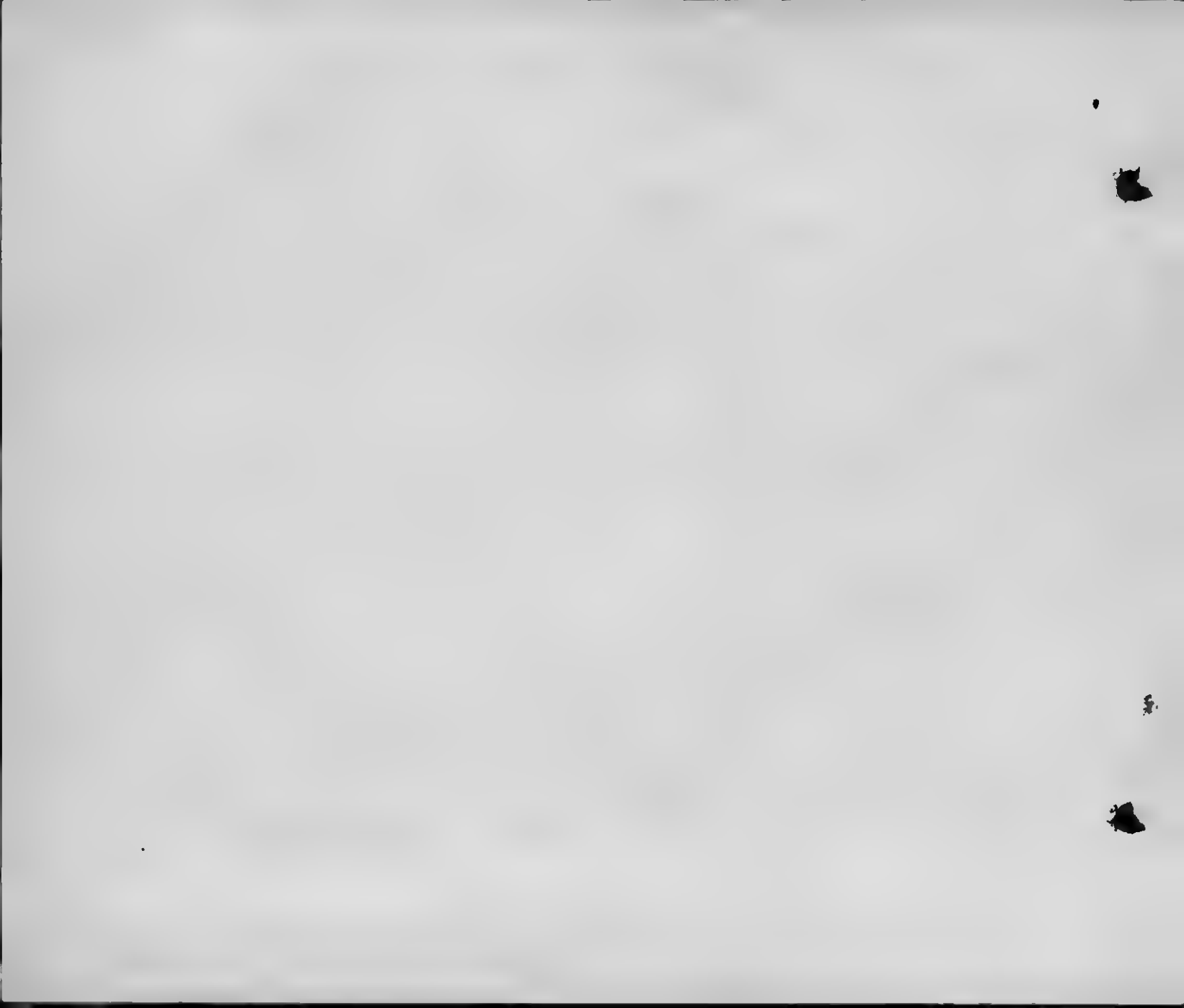
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Balto</u>	MARYLAND	STATE <u>md</u>	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Catonsville</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town) <u>Balls</u>	3V01-4
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Rich Haven Ave</u>	<u>Chickley Best Field</u>	STREET ADDRESS (If rural, give location) <u>4114 Glenhurst Rd</u>	
3. NAME OF DECEASED: (First) <u>Edmond</u> (Middle) <u>F</u> (Last) <u>Rest</u> 58.		4. DATE OF DEATH (Month) <u>Dec</u> (Day) <u>4</u> (Year) <u>1953</u>	
5. SEX: <u>m</u>	6. COLOR OR RACE: <u>w</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>Nov 1, 1918</u>
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>Builder</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Max Wilson Co</u>	9. AGE last birthday: <u>37</u> yrs. IF UNDER 1 YEAR: Months Days Hours Min.
11. BIRTHPLACE (State of foreign country): <u>Balto md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>John W Rest</u>		14. MOTHER'S MAIDEN NAME: <u>Suffe Raston</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk) <u>yes</u> <u>WW II</u>		16. SOCIAL SECURITY No.: <u>21601 1531</u>	
17. INFORMANT & ADDRESS: <u>4114</u> <u>John W Rest Glenhurst Rd</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		INTERVAL BETWEEN ONSET AND DEATH
973.1 Immediate cause (a) <u>asphyxiation by</u> DUE TO Antecedent cause(s) (b) <u>Carbon monoxide gas</u> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c) <u>suicide</u>		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>from automobile. Used but for</u>		
19a. DATE OF OPERATION: <u>Dec 4, 55</u>	19b. MAJOR FINDING OF OPERATION: <u>Exhaust into closed auto trunk</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OF CONTRIBUTING CAUSE OF DEATH	21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: <u>Farm fall Catonsville</u>	21c. (City or town) (County) (State) <u>Balls md</u>
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY: <u>Dec 4, 55 2:30 P.M.</u>	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>Used gas from auto exhaust</u>
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		
SIGNATURE <u>Leo W Kieffer</u> 1010 Redman		
CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>Dec 4, 53</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>		
23. BURIAL, CREMATION, REMOVAL (Specify): <u>BURIAL</u>	DATE THEREOF: <u>DEC 7/53</u>	NAME OF CEMETERY OR CREMATORY: <u>LORRRAINE PARK</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE: <u>Harry H. Witzke</u>	24. FUNERAL DIRECTOR: <u>4101 EDMONDSON AVE.</u>
		LOCATION (City, town, or county) (State) <u>WOODLAWN, MD.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



11701

CERTIFICATE OF DEATH

Reg. Dist. No.

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A5C 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTO</u>		STATE <u>MD</u> COUNTY <u>BALTO</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>EDGEWATER 19</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>EDGEWATER 19</u>	
TOWN <u>EDGEWATER 19</u>		LENGTH OF STAY (in this place) <u>14 YRS</u>		TOWN <u>EDGEWATER 19</u>		TOWN <u>EDGEWATER 19</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>3012 DELMAR AVE.</u>				STREET ADDRESS (If rural give location) <u>3012 DELMAR AVE.</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>ISAAC MILTON RILAND</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>12-24-1953</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>18 JUNE 1875</u>	9. AGE last birthday <u>80</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HELPER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BOX MFR</u>		11. BIRTHPLACE (State or foreign country) <u>PENNA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>OHAS RILAND</u>				14. MOTHER'S MAIDEN NAME <u>SMITH DISH</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unk.) <u>NO</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-20-5360</u>		17. INFORMANT & ADDRESS <u>MRS. HAROLD J. GREENAWALD - SAME</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Intermittent Diabetes</u>				INTERVAL BETWEEN ONSET AND DEATH <u>34 1</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized Arteriosclerosis</u>				10 yrs			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>U</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July</u> 19 <u>52</u> to <u>Dec 24</u> , 19 <u>53</u> , that I last saw the deceased alive on <u>Dec 24</u> , 19 <u>53</u> , and that death occurred at <u>11:30 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>J. T. Means</u> M.D.				ADDRESS (Street, city, town, state) <u>520 St. Balto. 19 Md</u> DATE SIGNED <u>12/25/53</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>12/28/55</u>		NAME OF CEMETERY OR CREMATORY <u>ENGLISH UNION</u>		LOCATION (City, town, or county) (State) <u>FRIEDENSBURG, VA.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Dawson L. Farber</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Propp / Dudley / Hurdell, INC</u>		ADDRESS	
DATE <u>12/28/55</u>							



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 12, Film G190, 12/12/55 bh

11702

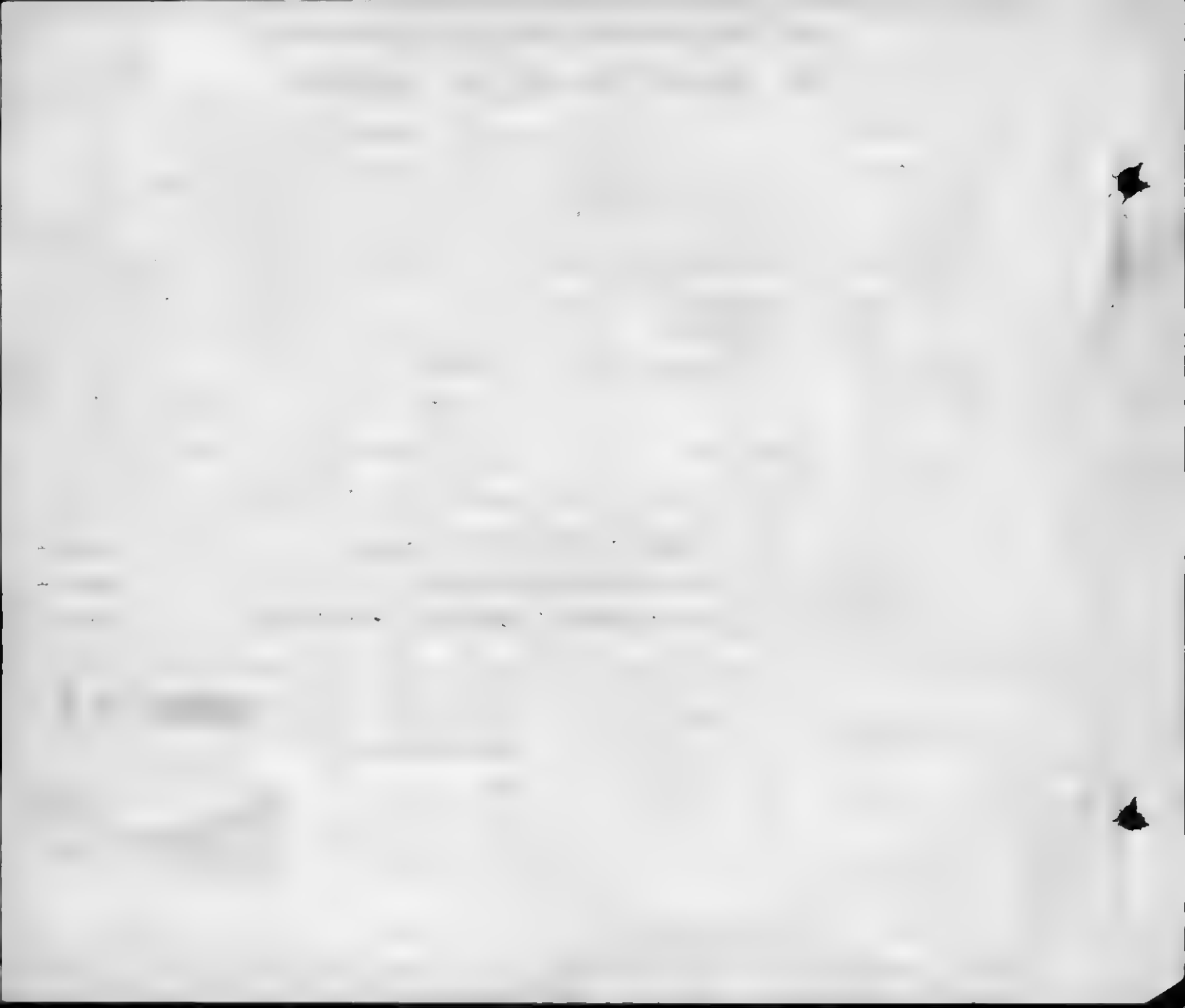
CERTIFICATE OF DEATH

11700

30

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTIMORE</u>		STATE <u>Md.</u>		COUNTY <u>Balto.</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>52 PATONS VILLE</u>		LENGTH OF STAY (in this place) <u>3 yrs. 7 mo.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Balto. (15)</u>		<u>2 V</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>14 Spring Grove Hospital</u>		STREET ADDRESS (If rural give location) <u>4215 PENHURST AVE.</u>					
3. NAME OF DECEASED (Type or Print) <u>FIVEL (PHOEBUS) RUBINSTEIN</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>12 - 7 - 1955</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>10-20-1880</u>	9. AGE last birthday <u>75</u> yrs.	IF UNDER 1 YEAR Months <u>1</u> Days <u>17</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GROCCER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (State or foreign country) <u>POLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>MORRIS RUBINSTEIN</u>				14. MOTHER'S MAIDEN NAME <u>MIRIAM BLATT</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u></u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT & ADDRESS <u>FLORA-RUBINSTEIN-WIFE (ABOVE)</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<u>420-1</u> IMMEDIATE CAUSE (A) <u>Inferative myocardial fibrosis</u>						<u>1 year</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Obliterative pericarditis</u>						<u>1 year</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Arteriosclerotic cardiovascular disease</u>						<u>years</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5-19-52</u> to <u>12-7-</u> 19 <u>55</u> that I last saw the deceased alive on <u>12-7-</u> 19 <u>55</u> and that death occurred at <u>9:20 PM</u> from the causes and on the date stated above.							
SIGNATURE <u>Harold E. Calverley M.D.</u>		DATE THEREOF <u>12/19/55</u>		NAME OF CEMETERY OR CREMATORY <u>Harold E. Calverley</u>		LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		24. REC'D BY REGISTRAR <u>V. E. Harris</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Harold E. Calverley M.D.</u>		ADDRESS <u>1124-26th St. N.W.</u>	



11553

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11701

Reg. Dist.

No. 42

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY	Baltimore	STATE	Maryland
CITY (If outside corporate limits, write RURAL OR and give nearest town)	Lansdowne	COUNTY	Baltimore
TOWN	Lansdowne	CITY (If outside corporate limits write RURAL and give nearest town)	Lansdowne
HOSPITAL OR INSTITUTION OR STREET ADDRESS	200 Second Avenue	STREET ADDRESS	200 Second Avenue

3. NAME OF DECEASED:	(First)	(Middle)	(Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
(Type or Print)	CLARENCE	L.	RUDOLF, SR.	Dec.	16,	19	55
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
male	white	married	Nov. 27, 1897	58	Yrs.	Months	Days
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?			
Picture Painter - Bell Service			Baltimore, Md.	U.S.A.			

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
John Martin Rudolf	Alice G. Anzmann
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)	16. SOCIAL SECURITY No.:
no	216-10-9834
17. INFORMANT & ADDRESS:	200 Second Ave.
Mrs. Elizabeth F. Rudolf, Lansdowne, Md.	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		INTERVAL BETWEEN ONSET AND DEATH
<p>4211</p> <p>Immediate cause (a) DUE TO</p> <p>Coronary Thrombosis</p> <p>Antecedent cause(s) (b) DUE TO</p> <p>Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)</p>		
<p>11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</p>		

19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY?
		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE *Wm. McKieffer* 1010 Red Lion

CHIEF MEDICAL EXAMINER ☐ DATE SIGNED *Dec 16 55*

DEPUTY MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAM. ☐

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
burial	12/20/55	Meadowridge Cemetery	Elkridge,	Maryland
DATE RECD BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<i>Dec 16 55</i>	<i>Wm McKieffer</i>	<i>Wm. Cook, Inc.</i>	1217 St. Paul Street	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 30 1955

BUREAU V. S.

1 **INSTRUCTIONS** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

2 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

3 **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11702

11704

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
TOWN <u>Owings Mills Md.</u>		<u>50 Years</u>		TOWN <u>Owings Mills Md.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>Gwynbrook Ave.</u>				<u>Gwynbrook Ave.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Harry</u> (Middle) <u>C.</u> (Last) <u>Rutter</u> Sr.				(Month) <u>December</u> (Day) <u>18</u> (Year) <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Widowed</u>	<u>Feb. 5, 1875</u>	<u>80</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Painter & Paper Hanger</u>		<u>Hanger</u>		<u>Maryland</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Edward T. Rutter</u>				<u>Marian J. Sparks</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>None</u>		<u>Carroll Rutter, Owings Mills, Md.</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
443X IMMEDIATE CAUSE (A) <u>Myocarditis - chronic</u>				<u>2 yrs</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>decompensating</u>				<u>5 yrs</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>atherosclerosis - general</u>				<u>5 yrs</u>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> M. <input checked="" type="checkbox"/> Not while <input type="checkbox"/> el work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1-7-55</u> to <u>12-18-55</u> , that I last saw the deceased alive on <u>12-18-55</u> , and that death occurred at <u>7:05</u> P.M. from the causes and on the date stated above.							
SIGNATURE <u>James G. Saffell</u>				ADDRESS (Street, city, town, state) <u>Reisterstown Md</u> DATE SIGNED <u>12-19-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Dec. 21, 1955</u>		<u>Pleasant Hill</u>		<u>Owings Mills, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>12-20-55</u>		<u>Mary B. Eline</u>		<u>J.F. Eline & Son's Reisterstown, Md.</u>			

RECEIVED

DEC 1957

EDWARD A. S.

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filled with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

11705 **CERTIFICATE OF DEATH**

Item 12, Film 191 1-6-56 et

Reg. Dist. No. 30

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		LENGTH OF STAY (In this place) <u>1 month</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>2901 Longshore Avenue</u>		OR TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove State Hosp.</u>				STREET ADDRESS (If rural give location) <u>Baltimore</u>			
3. NAME OF DECEASED (First) <u>Eva</u> (Middle) <u>Schaefer</u> (Last) <u>Schaefer</u>				4. DATE OF DEATH (Month) <u>December</u> (Day) <u>30</u> (Year) <u>1955</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>4-17-1873</u>	9. AGE last birthday <u>82</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Kasper Ruell</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT'S ADDRESS <u>Spring Grove State Hosp.</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
1. IMMEDIATE CAUSE (A) <u>Uremia</u>				INTERVAL BETWEEN ONSET AND DEATH			
2. ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic Nephrosclerosis</u>							
3. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Generalized Arteriosclerosis</u>							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the Deceased from <u>11-30-</u> , 19 <u>55</u> , to <u>12-30-</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12-30-1955</u> and that death occurred at <u>10:40 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>James K. Werby</u> M.D.				DATE SIGNED <u>12-30-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Jan. 2, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Parkwood</u>		LOCATION (City, town, or county) (State) <u>Parkville, Md.</u>	
24. REC'D BY REGISTRAR DATE <u>JAN 1 1956</u>		REGISTRAR'S SIGNATURE <u>J. E. Harry</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Ullrich Funeral Home 4210 Belair Road.</u>			

THOMAS V. S.

JAN 4



TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12575

11703

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Balto.</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Towson 4</u>		<u>about 4 yrs.</u>		TOWN <u>Towson, Md.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1803 Ellen Kidge Road</u>				STREET ADDRESS (If rural give location) <u>1803 Ellen Kidge Road</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>LeBarton</u> (Middle) <u>S.</u> (Last) <u>Rush Sr.</u>				(Month) <u>12</u> (Day) <u>28</u> (Year) <u>55</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>W.</u>	8. DATE OF BIRTH <u>June 15, 1888</u>	9. AGE last birthday <u>67</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
					Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Wardmaster</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>B&O. R.R.</u>	11. BIRTHPLACE (State or foreign country) <u>Hyndman, Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Charles Rush</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Louise Schaeffer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. <u>212-10-4042A</u>		17. INFORMANT & ADDRESS <u>B. Stanley Rush 1804 Ellen Kidge</u>			
(If Yes, give war or dates of service)							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
1. IMMEDIATE CAUSE (A) <u>metastatic malignancy</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Indef</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Malignant melanoma</u>				<u>Indef</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Arteriosclerotic heart disease</u>				<u>Indef</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> <input type="checkbox"/>		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>8/21/53</u> , 19....., to <u>12/28/55</u> , 19....., that I last saw the deceased alive on <u>12/27/55</u> , 19....., and that death occurred at <u>5:40 P.</u> M., from the causes and on the date stated above. <u>12/28/55</u>							
SIGNATURE <u>Robert E May</u>				ADDRESS (Street, city, town, state) <u>1200 Woodbourne Av. Baltimore</u>			
DATE SIGNED							
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>12/30/55</u>		NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>		LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Malcolm Gray</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Loring Myers</u>		ADDRESS <u>5005 Park Heights Baltimore 15, Md.</u>	
DATE <u>12/28/55</u>							

3.1.11.11

JAN 11

1.1.11.11

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

11549

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

11704

CERTIFICATE OF DEATH

Reg. Dist. No. 41

Item 12, Film 6121 1-17-56 et

1. PLACE OF DEATH: COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Md.</u> COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>TOWN</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>DeBoyle Ave.</u> (22)		STREET ADDRESS (If rural, give location) <u>DeBoyle Ave.</u> (28)	
3. NAME OF DECEASED (First) (Middle) (Last) <u>Charles H. Schmid Sr.</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Dec. 16</u> <u>58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>April 7-1890</u>
9. AGE last birthday <u>65</u> yrs.		10. DATE OF BIRTH <u>Dec. 16</u> <u>58</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Auto. Mechanic</u>	
11. FATHER'S NAME <u>Carl L. Schmid</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. MOTHER'S MAIDEN NAME <u>Wm. Rose Muraro</u>		14. BIRTHPLACE (State or foreign country) <u>Germany</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Mrs. Rose Muraro</u> <u>6727 Roberts Ave.</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>myocardial infarction</u>		<u>1 hr</u>	
Antecedent cause(s) (b) <u>arteriosclerosis / generalized</u>		<u>?</u>	
(c) <u>peripheral vascular</u>		<u>3 yrs</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>April</u> , 19 <u>52</u> , to <u>Dec. 4</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Dec. 16</u> , 19 <u>55</u> , and that death occurred at <u>8 P.</u> m., from the causes and on the date stated above.			
SIGNATURE <u>John H. Miller</u>		ADDRESS <u>576 Beechdale</u> DATE SIGNED <u>Dec. 20, 1955</u>	
23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>Dec. 20-1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Landon St. Cem.</u>		LOCATION (City, town, or county) (State) <u>Balto.</u> <u>Md.</u>	
DATE REC'D BY LOCAL REG. <u>2-19-56</u>		24. FUNERAL DIRECTOR <u>John H. Miller</u> <u>2334 Jefferson St.</u>	



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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

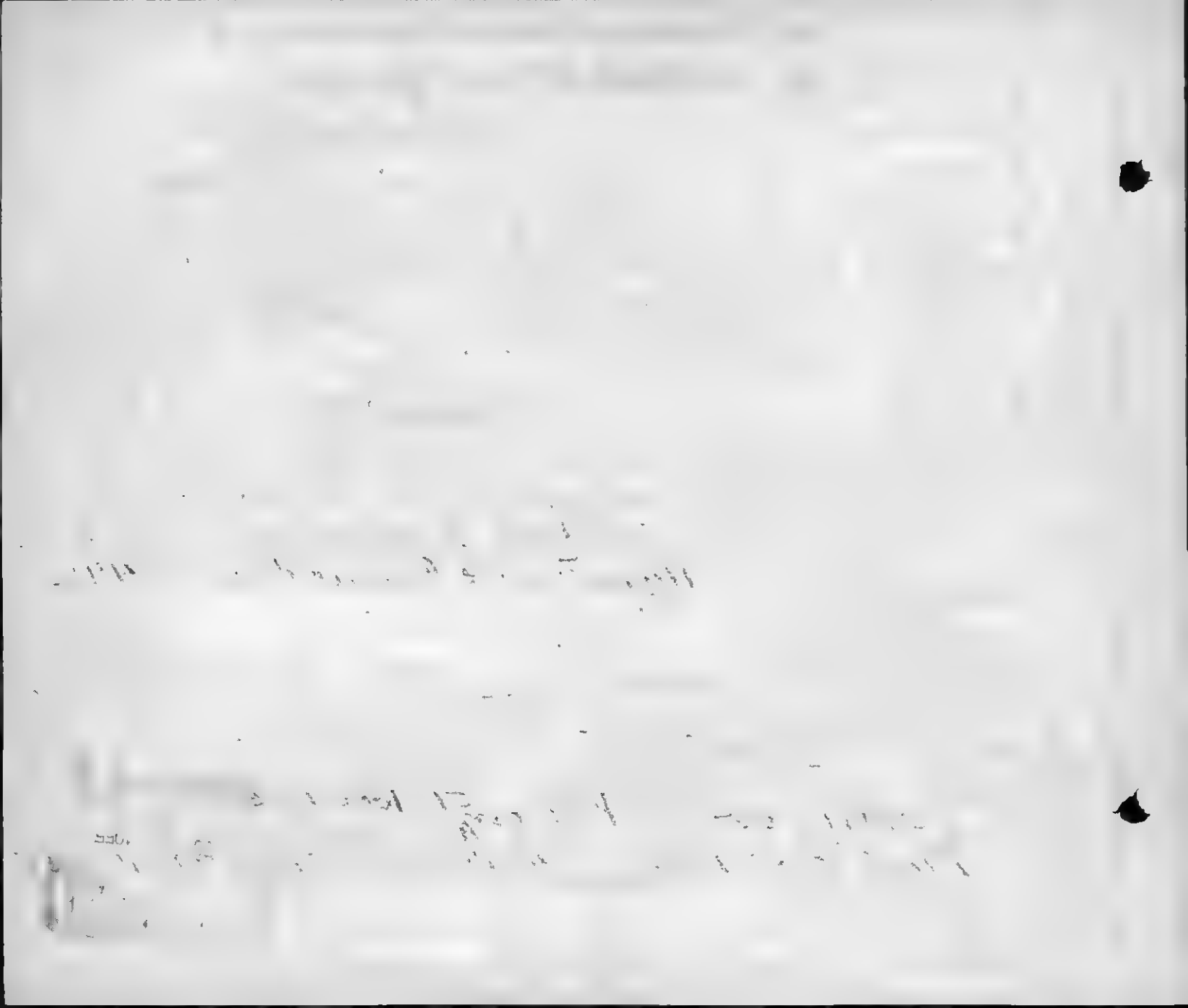
11705

11706

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		STATE <u>MARYLAND</u>		STATE <u>M.</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Catonsville</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>		STREET ADDRESS (If rural give location) <u>3835 Wilkerson Ave.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Caton Ridge Nursing Home</u> <u>3835 Wilkerson Lane</u>							
3. NAME OF DECEASED (Type or Print) <u>Elizabeth H. Schmidl</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Dec. 1/55</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>		8. DATE OF BIRTH <u>Sept. 2, 1899</u>	
9. AGE last birthday <u>56</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Louis Schmidl</u>				14. MOTHER'S MAIDEN NAME <u>Anna</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mrs. Dorothy Smith, 4211 Colborne Rd</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				12 hours			
445X IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>				4 yrs			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 5, 1951</u>, to <u>Dec 1, 1955</u>, that I last saw the deceased alive on <u>Sept. 19, 1955</u>, and that death occurred at <u>8:27 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Pearl Pass Mue</u>		DATE SIGNED <u>12-2-55</u>		ADDRESS (Street, city, town, state) <u>4001 Wilkins Ave Baltimore Md</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Buried</u>		DATE THEREOF <u>03. 3/55</u>		NAME OF CEMETERY OR CREMATORY <u>West Holy Redeem or</u>		LOCATION (City, town, or county) (State)	
24. REC'D BY REGISTRAR <u>DEC 2 1955</u>		REGISTRAR'S SIGNATURE <u>T. E. Hays</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Harry H. Witte</u>		ADDRESS <u>101 E. 1st St. Baltimore</u>	



11707

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Balt</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Catonsville</u>		LENGTH OF STAY (in this place) <u>4 mo.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>anburt</u>		<u>51</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Ridgeway Manor Nursing Home 5743 Edmondson Ave.</u>				STREET ADDRESS (If rural give location) <u>1265 Stearns Ave Balt, 27, Md</u>			
3. NAME OF DECEASED: (First) <u>GEORGE</u>		(Middle) <u>S</u>		(Last) <u>SCHMIDT</u>		4. DATE OF DEATH: (Month) <u>Dec.</u> (Day) <u>1</u> (Year) <u>1955</u>	
5. SEX: <u>M</u>		6. COLOR OR RACE: <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Wid.</u>		8. DATE OF BIRTH: <u>9/23/1977</u>	
9. AGE last birthday: <u>78</u> yrs.		10. MONTHS: <u>78</u>		11. DAYS: <u>78</u>		12. HOURS: <u>78</u>	
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): <u>unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>unknown</u>		11. BIRTHPLACE (State or foreign country): <u>unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>unknown</u>				14. MOTHER'S MAIDEN NAME: <u>unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>unk.</u>		16. SOCIAL SECURITY No.: <u>215-05 7978</u>		17. INFORMANT & ADDRESS: <u>Nursing Home records</u>			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<p>331X Immediate cause (a) <u>Cerebral hemorrhage</u> DUE TO</p> <p>Antecedent causes (b) <u>Hypertension</u> DUE TO</p> <p>(c) <u>None</u></p>							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>None</u>							
19a. DATE OF OPERATION: <u>None</u> 19b. MAJOR FINDINGS OF OPERATION: <u>None</u>							
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21. ACCIDENT (Specify) <u>None</u>		PLACE (Home, farm, factory, street, office bldg., etc.) <u>None</u>		(CITY OR TOWN) <u>None</u>		(COUNTY) <u>None</u>	
HOMICIDE <u>None</u>		INJURY <u>None</u>		(STATE) <u>None</u>			
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>None</u>		INJURY OCCURRED (Specify) <u>None</u>		HOW DID INJURY OCCUR? <u>None</u>			
While at Work <input type="checkbox"/>		Not While At Work <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from <u>Jan</u> , 1953, to <u>Dec</u> , 1955, that I last saw the deceased alive on <u>1 Dec</u> , 1955, and that death occurred at <u>4:15 PM</u> , from the causes and on the date stated above.							
SIGNATURE (Degree or title) <u>William Goodman, M.D.</u>				ADDRESS <u>- 1334 S. Jefferson Ave. - Balt, 27, Md</u>		DATE SIGNED <u>10-25-55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		DATE THEREOF <u>12-5-55</u>		NAME OF CEMETERY OR CREMATORY <u>BALTIMORE CEM.</u>		LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>	
DATE REC'D BY LOCAL REGISTRAR <u>12/25</u>		REGISTRAR'S SIGNATURE <u>W. H. Hedrick</u>		24. FUNERAL DIRECTOR <u>Joseph T. Ambrose</u>		ADDRESS <u>1328 S. Jefferson Ave. - Balt.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

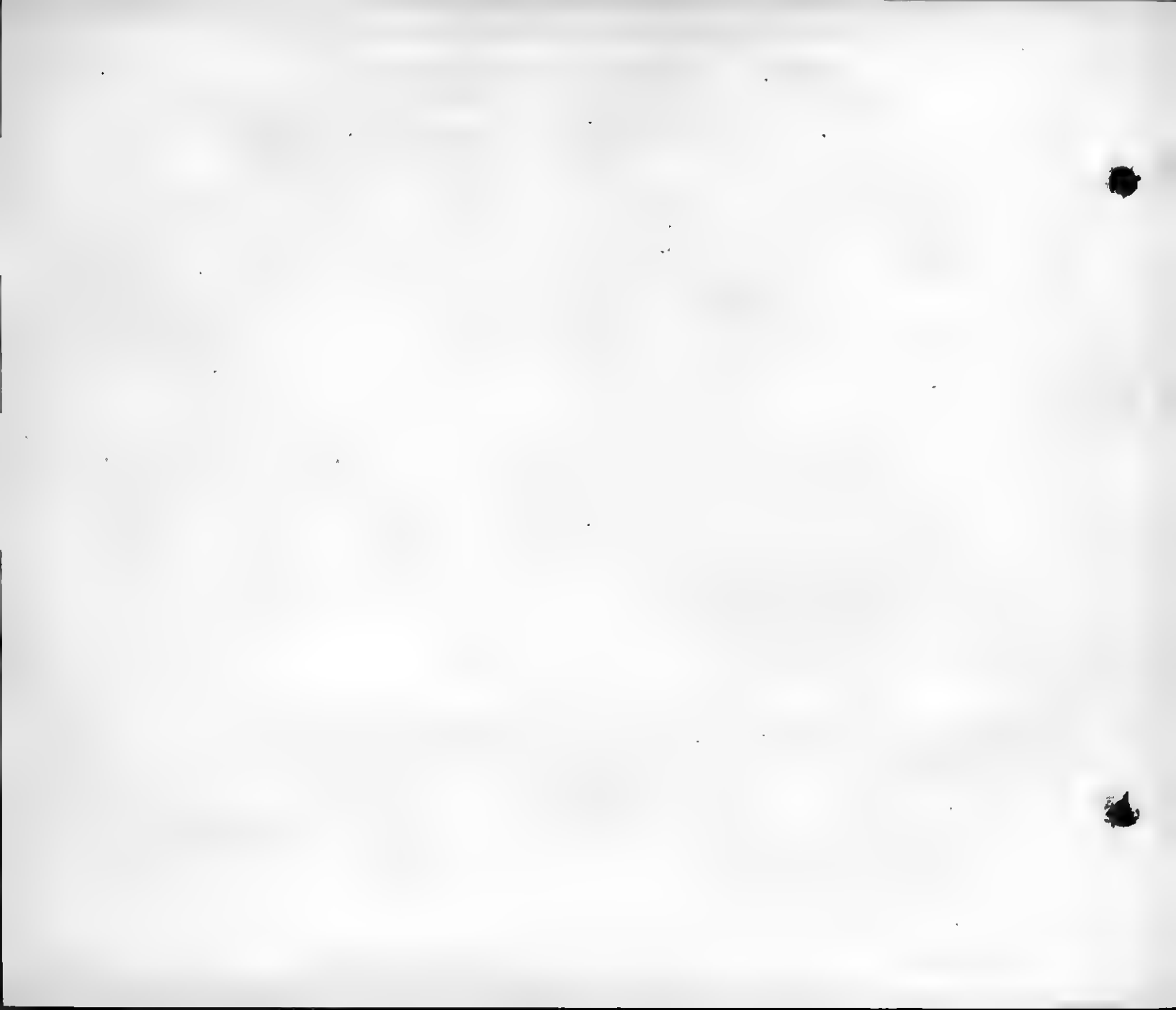
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11708

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH: 7914 Ruxway Road		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Balto.	MARYLAND	STATE Md.	COUNTY
CITY (If outside corporate limits, write RURAL or and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Sorenson Nursing Home		STREET ADDRESS (If rural give location) 1110 N. Bradford St.	
3. NAME OF DECEASED: (First) MAX (Middle) T. (Last) SCHROETER		4. DATE (Month) (Day) (Year) OF DEATH: DEC. 10 19 55	
5. SEX: male	6. COLOR OR RACE: white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widowed	8. DATE OF BIRTH: Dec. 18, 1871
9. AGE last birthday: 83 yrs.		10. IF UNDER 1 YEAR Months 11 Days 22	11. IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter		10B. KIND OF BUSINESS OR INDUSTRY: self employed	
11. BIRTHPLACE (State or foreign country): Germany		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME: Schroeter		14. MOTHER'S MAIDEN NAME: Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) no		16. SOCIAL SECURITY NO. LO	
17. INFORMANT & ADDRESS: Mr. Edmund H. Schroeter - 1110 N. Bradford St.			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) Generalized toxemia		3 days	
ANTECEDENT CAUSE (B) Gangrene back, Peripheral vascular disease		1 month	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) General arteriosclerosis		5 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Hypertension arterial.		5 years	
19A. DATE OF OPERATION: no operation		19B. MAJOR FINDINGS OF OPERATION: no operation	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.) none	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? none			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: none		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
21F. HOW DID INJURY OCCUR? none			
22. I hereby certify that I attended the deceased from Oct 3, 1955 to Dec. 10, 1955, that I last saw the deceased alive on Dec. 6th, 1955, and that death occurred at 4.45 M, from the causes and on the date stated above.			
SIGNATURE James Graham Munter		DATE SIGNED 1-14-55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 12/13/55	
NAME OF CEMETERY OR CREMATORY Parkwood Cem.		LOCATION (City, town, or county) Balto., Md.	
DATE REC'D BY LOCAL REGISTRAR		24. FUNERAL DIRECTOR ADDRESS	
REGISTRAR'S SIGNATURE		M. J. Dickson & Sons - Balt. 17, Md.	



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 14 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11709

CERTIFICATE OF DEATH

11708

Reg. Dist. No. 31

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL or end give nearest town) TOWN <u>Hollofield</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Daniels</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Hollofield</u>				STREET ADDRESS (If rural give location) <u>Hollofield</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>CARSON HENRY SETTLES</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Dec. 22, 1955</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>6-26-1891</u>	9. AGE last birthday <u>64</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Fannie Henry</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-01-9432</u>		17. INFORMANT & ADDRESS <u>Clarence Settles, Daniels, Md.</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						16. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Carcinoma of Colon</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan. 1954, to Dec. 22, 1955, that I last saw the deceased alive on Dec. 22, 1955, and that death occurred at 10:00 A.M. from the causes and on the date stated above. SIGNATURE <u>Wm. E. Martin</u> ADDRESS (Street, city, town, state) <u>Randallstown Md.</u> DATE SIGNED <u>Dec. 23, 55</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12-24-55</u>		NAME OF CEMETERY OR CREMATORY <u>Good Shepherd</u>		LOCATION (City, town, or county) (State) <u>Ellicott City, Md.</u>	
24. REC'D BY REGISTRAR DATE <u>12/23/55</u>		REGISTRAR'S SIGNATURE <u>Wm. E. Martin</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>F.C. Higinbotham, Ellicott City, Md.</u>			

BUREAU V. B.

1955

RECEIVED

11710

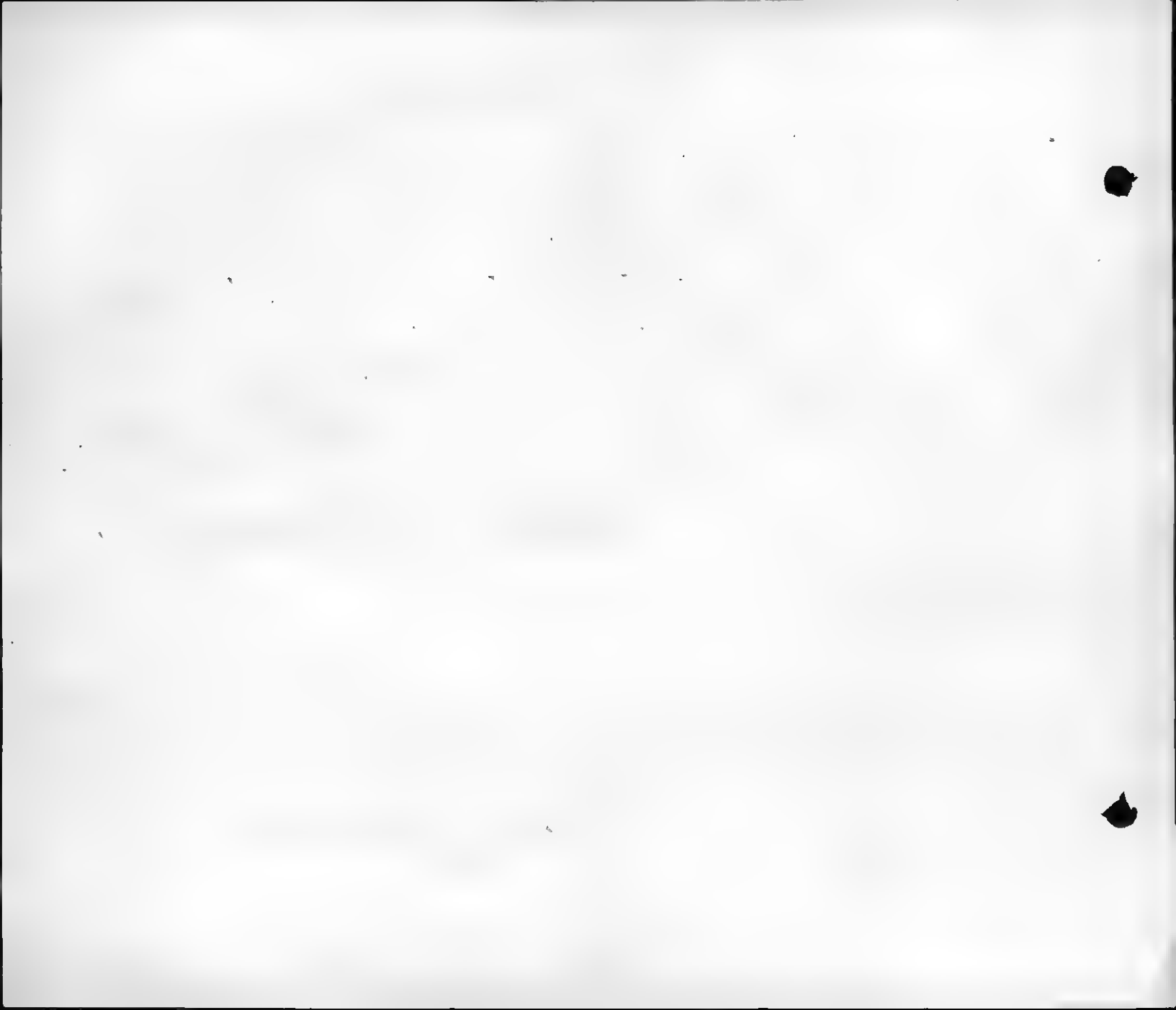
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED.			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Balto. City</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Mt. Wilson</u>		LENGTH OF STAY (in this place) <u>7 mo.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore (30) 3rd 14</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Mt Wilson State Hosp</u>				STREET ADDRESS (If rural give location) <u>1420 Reynolds St 1</u>			
3. NAME OF DECEASED:				4. DATE (Month) (Day) (Year)			
(First) <u>John</u>		(Middle) <u>Gabriel</u>		(Last) <u>Shade</u>		DATE OF DEATH: <u>12 12 1955</u>	
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. <u>married</u>	8. DATE OF BIRTH <u>2/25/16</u>	9. AGE last birthday <u>49</u> yrs		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Engineer</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>Southern Service</u>		11. BIRTHPLACE (State or foreign country): <u>Baltimore, Md.</u>	
13. FATHER'S NAME: <u>John Shade</u>				14. MOTHER'S MAIDEN NAME: <u>Viola McCullough</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>No</u> (If Yes, give war or dates of service)				17. INFORMANT & ADDRESS: <u>Mt. Wilson St. Hosp. Hospital Records, Mt. Wilson, Md.</u>			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Pulmonary Tuberculosis</u>						<u>10 yrs</u>	
ANTECEDENT CAUSE (B) <u></u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u></u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u></u>							
19A. DATE OF OPERATION: <u>0 Nov</u>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5/5</u> , 1955, to <u>12/12</u> , 1955, that I last saw the deceased alive on <u>12/12</u> , 1955, and that death occurred at <u>6:00 A</u> M, from the causes and on the date stated above.							
SIGNATURE <u>William Newman</u>				DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				DATE THEREOF <u>12/15/55</u>			
NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>				LOCATION (City, town, or county) (State) <u>Anne Arundel Co. Md</u>			
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE <u></u>		24. FUNERAL DIRECTOR <u>Wm. Cook, Inc. 1217 St Paul St</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



11711

CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH:

COUNTY *Baltimore* MARYLAND
 CITY (If outside corporate limits, write RURAL OR and give nearest town) *Harrisonville*
 TOWN *Harrisonville* LENGTH OF STAY (in this place) *6 year*
 HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE *Md.* COUNTY *Bald.*
 CITY (If outside corporate limits, write RURAL and give nearest town) *Harrisonville*
 TOWN *Harrisonville*
 STREET ADDRESS (If rural give location) *Randallstown P.O.*

3. NAME OF DECEASED:

(First) *George* (Middle) *Beverly* (Last) *Shultz*
 (Type or Print)

4. DATE OF DEATH:

(Month) *Dec.* (Day) *29* (Year) *1955*

5. SEX:

M

6. COLOR OR RACE:

W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):

Married

8. DATE OF BIRTH:

1-30-1892

9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.

63 yrs. Months Days Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired):

Minister

10b. KIND OF BUSINESS OR INDUSTRY:

Church

11. BIRTHPLACE (State or foreign country):

Pa.

12. CITIZEN OF WHAT COUNTRY:

U.S.A.

13. FATHER'S NAME:

Carry Shultz

14. MOTHER'S MAIDEN NAME:

Sarah E. Walker

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) If Yes, give war or dates of service)

No

16. SOCIAL SECURITY No.:

Unk.

17. INFORMANT & ADDRESS:

Mr. Laura E. Shultz, Randallstown, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

DUE TO

Antecedent causes (s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b)

DUE TO

(c)

Interval Between Onset and Death

1 y

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

12/29/55

19b. MAJOR FINDINGS OF OPERATION

152x

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

Accident

PLACE (Home, farm, factory, street, office bldg., etc.)

Office bldg.

PLACE (Home, farm, factory, street, office bldg., etc.)

Office bldg.

(CITY OR TOWN)

Randallstown

(COUNTY)

Bald.

(STATE)

Md.

TIME (Month) (Day) (Year) (Hour) OF INJURY

12/29/55 12:29 P.M.

INJURY OCCURRED

While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

Slipped on stairs

22. I hereby certify that I attended the deceased from 1954, to 12/29/1955, that I last saw the deceased

alive on 12/29/1955, and that death occurred at 6:55 P.M., from the causes and on the date stated above.

SIGNATURE

Wm. E. Martin

(Degree or title)

M.D.

ADDRESS

Randallstown Md.

DATE SIGNED

12/29/55

23. BURIAL, CREMATION, REMOVAL (Specify)

Burial

DATE THEREOF

1-1-56

NAME OF CEMETERY OR CREMATOR

Mt. Paran

LOCATION (City, town, or county)

Harrisonville, Bald. Md.

(State)

Md.

DATE REC'D BY LOCAL REGISTRAR

12/29/55

REGISTRAR'S SIGNATURE

Wm. E. Martin

24. FUNERAL DIRECTOR

Wm. E. Martin

ADDRESS

12/29/55

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 11711

11712

CERTIFICATE OF DEATH

Reg. Dist. No.

ly. The

THIS IS A PERMANENT RECORD. PLEASE TYPE, OR WITH PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN.

Every item of information so carefully supplied. Physicians: please write the causes of death clearly and let this certificate must be with the BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER

1. NAME OF DECEASED (Type or Print) SUSIE SMITH		2. DATE OF DEATH 12-14-55	
3. PLACE OF DEATH: A. Baltimore City, Maryland Baltimore County		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION 52 15 GARNET AVE.		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE (CATONSVILLE)	
D. STREET ADDRESS (If rural, give location) 15 GARNET AVE.		E. Yrs. 70 Mths. 11 Days	
5. SEX F.	6. COLOR OR RACE C.	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH 3-12-1876
9. AGE (In years last birthday) 79		10. AGE (In years last birthday) 79	11. AGE (In years last birthday) 79
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) ST. MARY'S Co. Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME THOMAS BEAN		14. MOTHER'S MAIDEN NAME LOTTIE UNKNOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO.	
17. INFORMANT LAS. SMITH		ADDRESS 15 GARNET AVE.	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) Uremia DUE TO (B) Nephritis DUE TO (C)			INTERVAL BETWEEN ONSET AND DEATH 14 days
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OF PART II		19A. DATE OF OPERATION	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
22. I certify that (I) (this hospital) attended the deceased from 10 December 1955 to 14 December 1955 , that (I) (we) last saw the deceased alive on 10 December 1955 , and that death occurred at 3:15 p.m. , from the causes and on the date stated above.			
23A. SIGNATURE C. R. Davidson		23B. ADDRESS 905 A Wintano Ave.	
23C. DATE SIGNED 14 Dec. 1955		23D. DATE SIGNED	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-17-55	
24C. NAME OF CEMETERY OR CREMATORY ST. PETERS CEM.		24D. LOCATION (City, town, or county) (State) BALTO. Md.	
DATE RECEIVED BY LOCAL REGISTRAR 19 Dec 15 1955		REGISTRAR'S SIGNATURE C. W. Davidson	
25. FUNERAL DIRECTOR Mr. R. A. Ellith & Son		ADDRESS	



11713

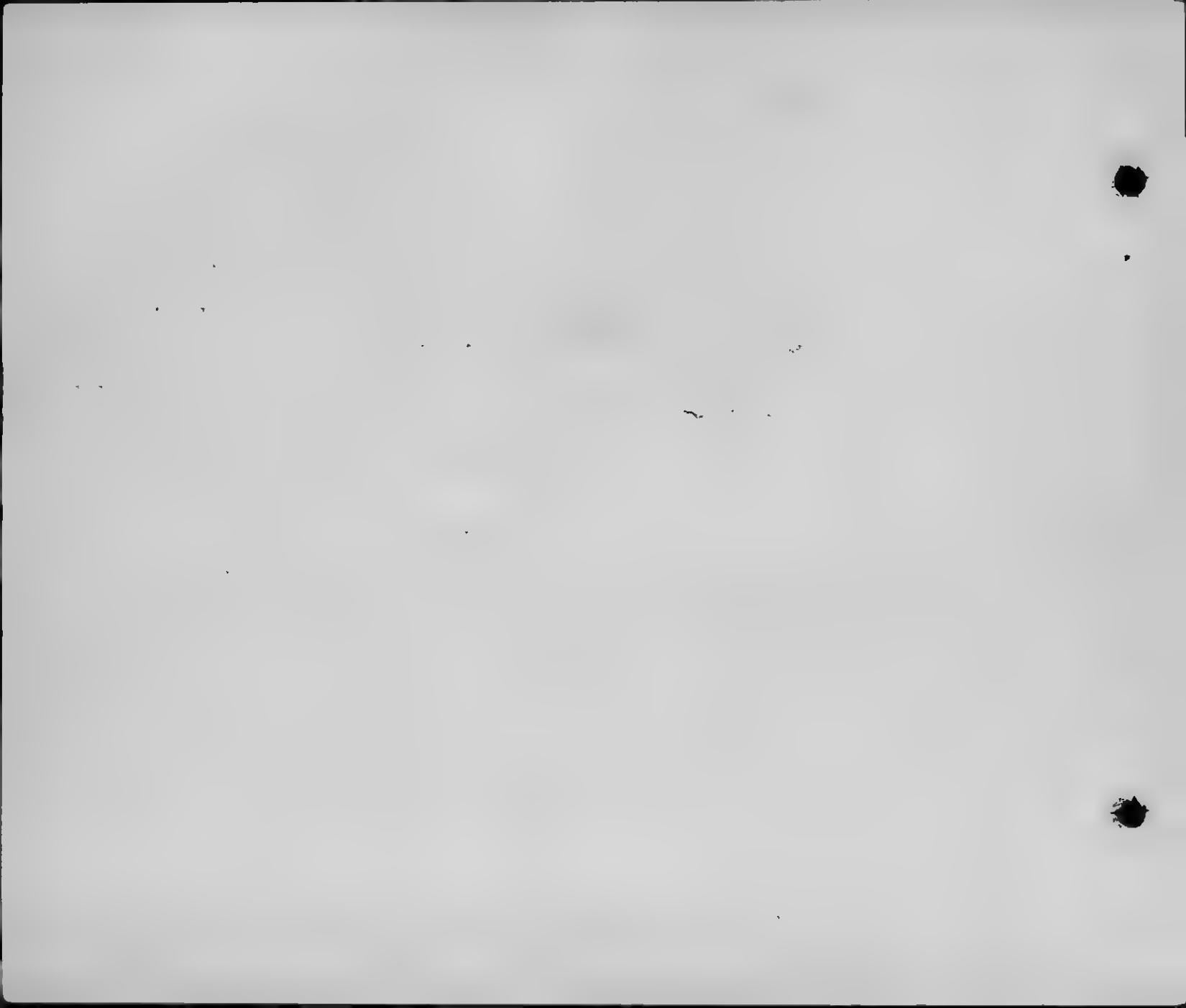
CERTIFICATE OF DEATH FOR MEDICAL EXAMINERS

Reg. Dist. No. 50

MARGIN RESERVED FOR BINDING

PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The more complete the information, the more valuable it will be. Especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH- COUNTY		Baltimore		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE		Maryland		COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN		Catonsville		LENGTH OF STAY (In this place)		1yr 4mo		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN		Baltimore	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		Spring Grove State Hospital		STREET ADDRESS		3612 Edmonson Av.		(If rural, give location)			
3. NAME OF DECEASED (Type or Print)		(First) Fannie		(Middle) Virginia		(Last) Snyder		4. DATE OF DEATH		(Month) (Day) (Year) Dec. 31, 1955	
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH		9. AGE last birthday		If under 1 year Months Days Hours Mins.	
Female		White		WIDOWED		Mar. 10, 1867		88 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		H. W.		11. BIRTHPLACE (State or foreign country)		Maryland		12. CITIZEN OF WHAT COUNTRY U.S.	
13. FATHER'S NAME		McDonald		14. MOTHER'S MAIDEN NAME		Unknown					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY No.		17. INFORMANT AND ADDRESS		Records: Spring Grove State Hospital					
18. MEDICAL CERTIFICATION											
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH										INTERVAL BETWEEN ONSET AND DEATH	
4 Immediate cause (a) Congestive heart failure											
Antecedent cause(s) (b) Arterio-sclerotic Cardio-vascular disease											
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) Unknown											
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.											
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION									
21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH		PLACE (Home, farm, factory, street, or office bldg., etc.) INJURY		(CITY OR TOWN)		(COUNTY)		(STATE)		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		HOW DID INJURY OCCUR?							
22. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/>											
SIGNATURE		(Degree or title)		ADDRESS		DATE SIGNED					
J. Edgar Hoover		M.D. J. Edgar Hoover		1010 Landon		31-1-56					
23. RIAL, CREMATION OR BURIAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)		(State)			
Burial		Jan. 3/56		Landon Pk.		Baltimore		Md.			
DATE FILED BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS					
1-3-56		L		Harry J. Witzke		4101 Edmonson					



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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be delivered for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11714

CERTIFICATE OF DEATH

11713

Reg. Dist. No. 33

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town.) TOWN <u>Parkton (rural)</u>		LENGTH OF STAY (in this place) <u>3 mos.</u>		CITY (If outside corporate limits, write RURAL and give nearest town.) TOWN <u>Parkton (rural)</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Pretty Boy Dam Rd.</u>				STREET ADDRESS (If rural give location) <u>Pretty Boy Dam Rd.</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>John Snyder</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>12-17-55</u> 19 <u>55</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>6-16-1915</u>	9. AGE last birthday <u>40</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Int. Harvester</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Edgar F. Snyder</u>				14. MOTHER'S MAIDEN NAME <u>Allie Klingerman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>217-07-3375</u>		17. INFORMANT & ADDRESS <u>Mrs. Eliz. Snyder, Parkton, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
401 IMMEDIATE CAUSE (A) <u>Coronary thrombosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12/12/55</u> , 19 <u>55</u> , to <u>12/17</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12/16/55</u> , 19 <u>55</u> , and that death occurred at <u>12</u> M., from the causes and on the date stated above.							
SIGNATURE <u>C. M. France</u> M.D.				ADDRESS (Street, city, town, state) <u>Parkton, Md.</u>		DATE SIGNED <u>12/18/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12-20-55</u>		NAME OF CEMETERY OR CREMATORY <u>Good Shepherd</u>		LOCATION (City, town, or county) (State) <u>Ellicott City, Md.</u>	
24. REC'D BY REGISTRAR DATE <u>12-20-55</u>		REGISTRAR'S SIGNATURE <u>Mary B. Elvine</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>L. Scott Brooks</u>		ADDRESS <u>Sparks, Md.</u>	

U. S. S.

1955

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11714

11715 CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Prince George's</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chillumville 29</u>		LENGTH OF STAY (in this place) <u>Since April 1952</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chillum</u>		11.2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove Hospital</u>				STREET ADDRESS (If rural give location) <u>406, Chillum Rd</u>		✓	
3. NAME OF DECEASED (Type or Print) <u>NINNIE</u> (First) (Middle) (Last) <u>SNYDERMAN</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>12 14 1955</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>W</u>	8. DATE OF BIRTH <u>6-18-74</u>	9. AGE last birthday <u>81</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>?</u> ✓	
13. FATHER'S NAME <u>unknown</u>				14. MOTHER'S MAIDEN NAME <u>Thelma Neumaier</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Raphael Sachs - Phila Pa.</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Arteriosclerosis Cordiac Disease</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized Arteriosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>9-12-1955</u> to <u>12-14-1955</u> , that I last saw the deceased alive on <u>12-14-1955</u> , and that death occurred at <u>5:50 a.m.</u> from the causes and on the date stated above.							
SIGNATURE <u>Rena Becker</u>				DATE SIGNED <u>12/14/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u>		DATE THEREOF <u>12/14/55</u>		NAME OF CEMETERY OR CREMATORY <u>Spring Grove Hosp. Catonsville Rd</u>		LOCATION (City, town, or county) <u>Prince George's - Pa.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>V. E. Harris</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Sal Johnson</u>		ADDRESS <u>1124-26 W. North Ave</u>	
DATE <u>Dec 15, 1955</u>							

U.S. A. 100

1005

1005

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11715

11716

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTIMORE</u>		STATE <u>MARYLAND</u> COUNTY		CITY (if outside corporate limits, write RURAL and give nearest town)		CITY (if outside corporate limits, write RURAL and give nearest town)	
CITY OR TOWN <u>BALTIMORE</u>		LENGTH OF STAY (in this place) <u>3/25/54-16/12/55</u>		TOWN <u>BALTIMORE</u>		STREET ADDRESS (if rural give location) <u>172 S. COLLINS AV. BALTO. 29</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>SPRING GROVE STATE HOSP</u>							
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>WILLIAM HENRY SOHN</u>				<u>12 16 1955</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>APRIL 17, 1880</u>	9. AGE last birthday <u>75</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MEAT WORKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MEAT PACKER</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM H. SOHN</u>				14. MOTHER'S MAIDEN NAME <u>ANN ELIZABETH SOHN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. <u>215-09-7596</u>		17. INFORMANT & ADDRESS <u>MRS. ANNA HEILAND, 172 S. COLLINS AV.</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<u>45.0 IMMEDIATE CAUSE (A) CARDIAC FAILURE</u>				<u>12/9/55</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
<u>(B) ARTERIOSCLEROSIS, GENERALIZED, SEVERE</u>				<u>12/16/55</u>			
<u>(C) ADVANCED AGE</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3/25</u>, 19<u>54</u>, to <u>12/16</u>, 19<u>55</u>, that I last saw the deceased alive on <u>12/16</u>, 19<u>55</u>, and that death occurred at <u>9:00 AM</u>, from the causes and on the date stated above.							
SIGNATURE <u>Stella Nachsch</u> M.D. <u>Spring Grove State Hospital</u>				DATE SIGNED <u>12/16/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>12-20-1955</u>		NAME OF CEMETERY OR CREMATORY <u>LODGE PARK CEM.</u>		LOCATION (City, town, or county) <u>BALTO. MD.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>V. E. Harry</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Stuman Schuch</u>		ADDRESS <u>3512 Madison Ave.</u>	
DATE							

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VE 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11716

11717

CERTIFICATE OF DEATH

Reg. Dist. No. 37

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cockeysville</u>		LENGTH OF STAY (in this place) <u>26 Mo.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Halperstown</u>		<u>2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Masonic Home of Md.</u>				STREET ADDRESS (If rural give location) <u>534 Summit Ave</u>			
3. NAME OF DECEASED (Type or Print) <u>William Frank Spahr</u>				4. DATE OF DEATH (Month) <u>Dec.</u> (Day) <u>20</u> (Year) <u>1955</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Sept. 11 1873</u>	9. AGE last birthday <u>82</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Foreman-B.R. West. Ind. Railroad</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Halperstown, Md.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Spahr</u>				14. MOTHER'S MAIDEN NAME <u>Mary Black.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Frank R. Smith Jr. - Cockeysville</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
18a. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>arterio-sclerotic Cardiovascular disease</u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct. 30, 1953</u> , to <u>Dec. 20, 1955</u> , that I last saw the deceased alive on <u>Dec. 19, 1955</u> , and that death occurred at <u>5:35</u> A.M. from the causes and on the date stated above.							
SIGNATURE <u>Walter T. Kues</u>				ADDRESS (Street, city, town, state) <u>Cockeysville</u>		DATE SIGNED <u>12/20/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Dec. 23, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Rest Haven</u>		LOCATION (City, town, or county) (State) <u>Halperstown Md.</u>	
24. RECEIVED BY REGISTRAR <u>DEC 22 1955</u>		REGISTRAR'S SIGNATURE <u>Anne MacRae</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook Inc</u>		ADDRESS <u>1217 St. Paul Street.</u>	

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11718

CERTIFICATE OF DEATH

11717

Reg. Dist. No. 38

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Cousin</u>		<u>8 yrs</u>		TOWN <u>Cousin</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>8640 Willow Oak Rd.</u>				STREET ADDRESS (If rural give location) <u>8640 Willow Oak Rd</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Anna May Spalding</u>				<u>12 29 1953</u>			
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH	
<u>Female</u>		<u>White</u>		<u>Married</u>		<u>5/10/1880</u>	
				<u>75</u> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>House work</u>		<u>at Home</u>		<u>Baltimore</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Thomas V. Early</u>				<u>Lucinda J. Draiger</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
				<u>8640 Rd.</u> <u>Mrs Edward J. Ward Willow Oak</u>			
18. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
<u>450.0 IMMEDIATE CAUSE (A) <u>Uremia</u></u>				INTERVAL BETWEEN ONSET AND DEATH			
<u>ANTECEDENT CAUSE(S) DUE TO <u>Generalized arteriosclerosis</u></u>							
<u>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Chronic renal arteriosclerosis</u></u>							
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
<u></u>		<u></u>		<u></u>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
<input type="checkbox"/>		<u></u>		<u></u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<u></u>		<u></u>		<u></u>			
22. I hereby certify that I attended the deceased from <u>11/5/49</u>, 19<u>49</u>, to <u>12/29</u>, 19<u>53</u>, that I last saw the deceased alive on <u>12/19</u>, 19<u>53</u>, and that death occurred at <u>9:15 A.</u> M., from the causes and on the date stated above.							
SIGNATURE				DATE SIGNED			
<u>Edmond Gray</u>				<u>M.D. 8525 York Road Bldg of Town 4 12-29</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>12/31/53</u>		<u>New Calhoun Cem.</u>		<u>4300 Old Hickory Rd.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>JAN 3 1955</u>		<u>Mabel Gray</u>		<u>John J. Egan & Son</u>		<u>481</u>	

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11719

CERTIFICATE OF DEATH

11718

Reg. Dist. No. 40

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>White Marsh</u>		LENGTH OF STAY (In this place) <u>27 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>White Marsh</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Bird River Road</u>				STREET ADDRESS (If rural give location) <u>Box 71, Bird River Road</u>			
3. NAME OF DECEASED (Type or Print) <u>JOSEPH J. STEFAN</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>December 22, 1955</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>March 6, 1905</u>	9. AGE last birthday <u>50</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Foreman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Florist</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Andrew Stefan</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth -----</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>215-07-9893</u>		17. INFORMANT & ADDRESS <u>Mrs. Jos. J. Stefan, White Marsh, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
42. IMMEDIATE CAUSE (A) <u>coronary occlusion</u>				INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>verru pneumonia</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec 18, 55</u> , 19 <u>55</u> , to <u>Dec 21, 55</u> , that I last saw the deceased alive on <u>Dec 18, 55</u> , and that death occurred at <u>Dec 21, 55</u> M., from the causes and on the date stated above.							
SIGNATURE <u>L. J. [Signature]</u>				ADDRESS (Street, city, town, state)		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>burial</u>		DATE THEREOF <u>12/26/55</u>		NAME OF CEMETERY OR CREMATORY <u>Oaklawn Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
24. REC'D BY REGISTRAR DATE <u>Dec 27, 1955</u>		REGISTRAR'S SIGNATURE <u>Dr. Walter Hemmets</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Lassman Funeral Home</u>		ADDRESS <u>7401 Belair Rd.</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

11719

11720

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Notch Cliff near Towson</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Notch Cliff near Towson</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Villa Maria Glenarm Rd</u>		STREET ADDRESS <u>Glenarm Rd</u>	
3. NAME OF DECEASED (Type or Print) <u>Sister Mary Barnaba Steinmetz</u>		4. DATE OF DEATH <u>December 10, 1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Nov. 18, 1862</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RELIGIOUS</u>	9. AGE last birthday <u>93</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Philadelphia, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Max Steinmetz</u>		14. MOTHER'S MAIDEN NAME <u>Theresa Thoneman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Sr. Mary Clara Notch Cliff, Md.</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause <u>4. 3. 10</u>	(a) <u>Ruptured Esophageal varix</u>	<u>See below</u>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) <u>Generalized Arterio Sclerosis</u>	<u>15 yrs.</u>
(c)		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct. 26....., 1953....., to Dec. 10....., 1955....., that I last saw the deceasedalive on Dec. 6....., 1955....., and that death occurred at 4:00 A......m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify)		DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>BURIAL</u>		<u>12-12-55</u>	<u>VILLA MARIA CEM.</u>	<u>NOTCH CLIFF NEAR TOWSON</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS			
		<u>Charles J. Seiler 9015 CONKLING ST BALTO. 44 MD.</u>			

MARGIN RESERVED FOR INDEXING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11720

11721

CERTIFICATE OF DEATH

Reg. Dist. No. 44

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be delivered for use as a burial transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		STATE <u>MARYLAND</u>		STATE <u>Maryland</u> COUNTY <u>Wicomico</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Fort Howard</u>		LENGTH OF STAY (In this place) <u>65 Days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Salisbury</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location) <u>Route #1</u>			
3. NAME OF DECEASED (Type or Print) (First) <u>JOHN</u> (Middle) <u>A.</u> (Last) <u>STEMPEL</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>December 24, 1955</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>5-30-90</u>	9. AGE last birthday <u>65</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Prospectville, Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>George Stempel</u>				14. MOTHER'S MAIDEN NAME <u>Annie F. Mullin</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If Yes, give war or dates of service) <u>Yes</u> <u>WW I</u>		16. SOCIAL SECURITY NO. <u>219-01-7341</u>		17. INFORMANT & ADDRESS <u>Clin. Rec. Vet. Adm. Hosp., Ft. Howard, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>423.1</u> IMMEDIATE CAUSE (A) <u>THROMBOSIS RIGHT CORONARY ARTERY WITH</u> ANTECEDENT CAUSE(S) <u>XXXXXXXXXX</u> <u>INFARCTION OF LEFT VENTRICLE</u>						RECENT	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>2/2</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) <u>M.</u>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct. 20, 1955</u> , to <u>Dec. 24, 1955</u> , that I saw the deceased alive <u>XXXXXXXXXX</u> and that death occurred at <u>2:50 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Donald D. Mark</u>		ADDRESS (Street, city, town, state) <u>M.D. VAH, FORT HOWARD, MARYLAND</u>		DATE SIGNED <u>12-24-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12-27-55</u>		NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>		LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>	
24. REC'D BY REGISTRAR <u>26 28 1955</u>		REGISTRAR'S SIGNATURE <u>Dawson L. Farley</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook-Blight, Inc.</u> ADDRESS <u>6009 Harford R., Balto. Md.</u>			

U.S. AIR FORCE

DEPT.

11722

CERTIFICATE OF DEATH

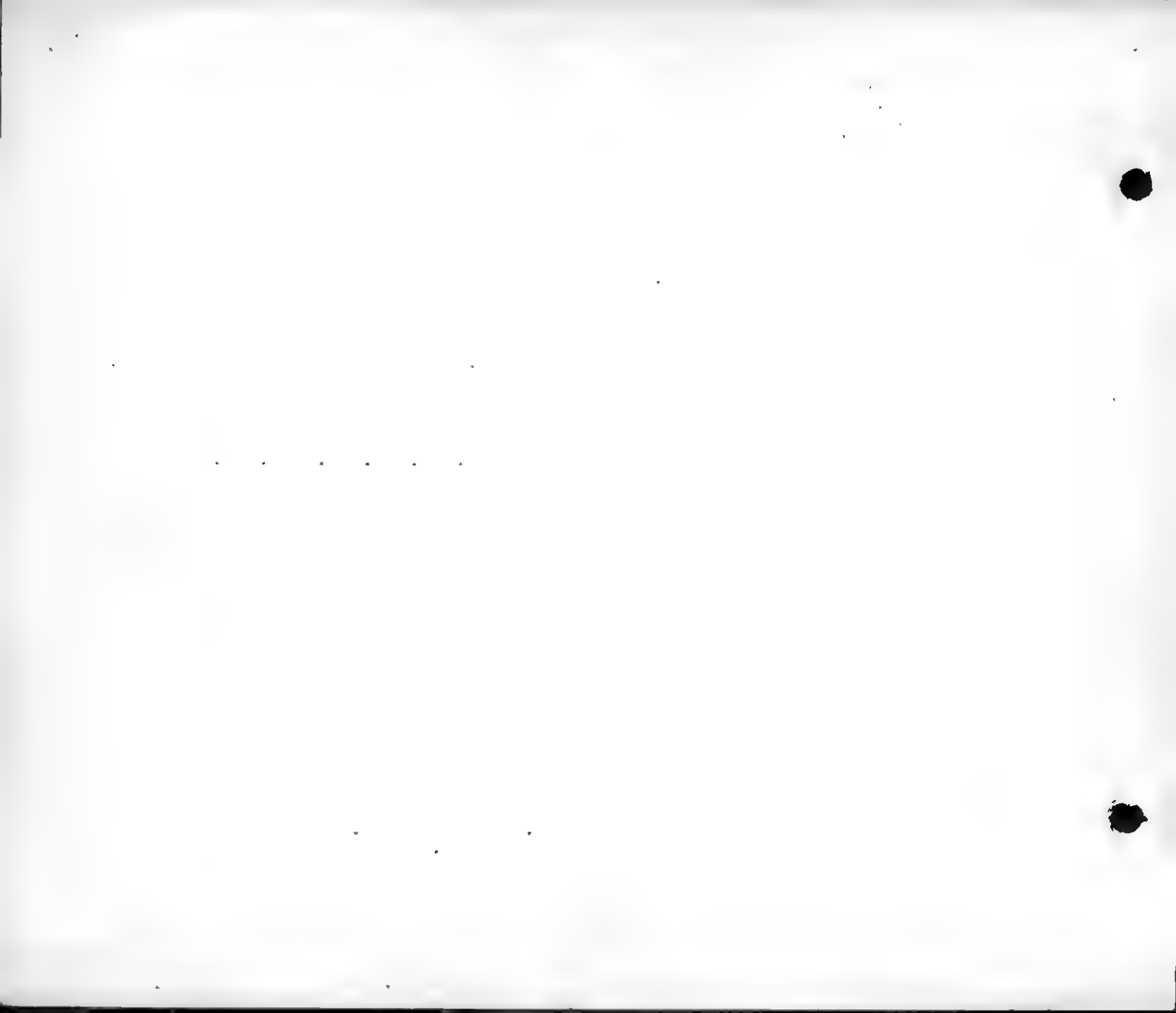
Reg. Dist. No.

44

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
X TOWN <u>Fort Howard</u>		<u>4 Days</u>		<u>Baltimore</u> <u>24 1 11</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location) <u>1600 Vincent Court</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH			
<u>JOSEPH T. STEWART</u>				<u>December 8 1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Male</u>	<u>Colored</u>	<u>Married</u>	<u>8/3/97</u>	<u>58</u> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Laborer</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Chemical Plant</u>		11. BIRTHPLACE (State or foreign country): <u>St. Marys County, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME: <u>William Stewart</u>				14. MOTHER'S MAIDEN NAME: <u>Amanda Thomas</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes WW I</u>		16. SOCIAL SECURITY NO. <u>214-03-4975</u>		17. INFORMANT & ADDRESS: <u>Clin. Rec. Vet. Adm. Hosp., Ft. Howard, Maryland</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<u>420.0</u>							
IMMEDIATE CAUSE (A) <u>ARTERIOSCLEROTIC HEART DISEASE</u>						<u>UNKNOWN</u>	
ANTECEDENT CAUSE (B) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u>						<u>UNKNOWN</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>260x</u>							
(C) <u>DIABETES MELLITUS</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>ARTERIO-SCLEROSIS, GENERALIZED</u>						<u>UNKNOWN</u>	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Dec. <u>4</u> , 19 <u>55</u> , to Dec. <u>8</u> , 19 <u>55</u> , that I saw the deceased <u>at work</u> and that death occurred at <u>8:45 AM</u> from the causes and on the date stated above.							
SIGNATURE <u>Irving Freeman</u>		ADDRESS <u>M. P. VAH, FORT HOWARD, MARYLAND</u>		DATE SIGNED <u>12/9/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12/12/55</u>		NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Dec 12, 1955</u>		REGISTRAR'S SIGNATURE <u>C. W. Medrich</u>		24. FUNERAL DIRECTOR <u>Charles R. Law</u>		ADDRESS <u>802 Madison Ave Balto. Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



11723

CERTIFICATE OF DEATH

Reg. Dist. No. 57

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Cockeysville</u>		<u>Years</u>		TOWN <u>Cockeysville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Balto. County Home</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>William</u> (Middle) <u>E.</u> (Last) <u>Sturm</u>				(Month) <u>Dec</u> (Day) <u>12</u> (Year) <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Single</u>	<u>June 27, 1893</u>	<u>52</u> yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>gardening</u>		<u>farmer</u>		<u>Pennsylvania</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Jeremiah Sturm</u>				<u>Lucy Wolf</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>213-10-40264</u>		<u>Balto. Co. Home Records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>arterio sclerotic Cardio-Vascular</u>						<u>4 yrs</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 1950</u> , to <u>Dec 1955</u> , that I last saw the deceased alive on <u>Dec 4</u> , 19 <u>55</u> , and that death occurred at <u>4:45 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>E. L. Smith</u>				ADDRESS (Street, city, town, state) <u>Cockeysville, Md</u>			
DATE SIGNED <u>12/12/55</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>12-13-55</u>		<u>St. Josephs Catholic</u>		<u>Sparks, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>12/12/55</u>		<u>Wm. J. Chikvat</u>		<u>J. Scott Brock</u>		<u>Sparks, Md.</u>	

INSTRUCTIONS

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TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly shall be detached for use as a burial transit permit.

VS A19C 1-55 10M

1. 1967

155 21

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

11723

11724

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Pikesville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Pikesville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>611 Peinstown Road</u>		STREET ADDRESS (If rural give location) <u>611 Peinstown Road</u>	
3. NAME OF DECEASED (First) <u>Charles Wilbert</u> (Middle) <u>Sullivan</u> (Last)		4. DATE OF DEATH (Month) <u>Dec</u> (Day) <u>18</u> (Year) <u>1955</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>Oct 7, 1903</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Staleman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Norm Windsor</u>	9. AGE last birthday <u>52</u> yrs. If under 1 year Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Garrison, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Horatio Sullivan</u>		14. MOTHER'S MAIDEN NAME <u>Mary Rogers</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>None</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT <u>Son Charles W. Sullivan Jr</u>		18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Subarachnoid hemorrhage</u>			
Antecedent cause(s) (b) <u>Arteriosclerotic CVD</u>			
(c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY) (STATE)
21. SUICIDE 21. HOMICIDE	INJURY		
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>5 Feb</u> , 19 <u>55</u> , to <u>18 Dec</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>18 Dec</u> , 19 <u>55</u> , and that death occurred at <u>9:10 P.m.</u> , from the causes and on the date stated above.			
SIGNATURE <u>Charles N. Williams</u>		DATE SIGNED <u>18 Dec 55</u>	
(Degree or title) <u>M.D.</u>		ADDRESS <u>Pikesville 8, Md.</u>	
23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF <u>12/21/55</u>	NAME OF CEMETERY OR CREMATORY <u>Druid Ridge</u>	LOCATION (City, town, or county) (State) <u>Pikesville Md.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE <u>[Signature]</u>	24. FUNERAL DIRECTOR <u>John F. Stansbury</u>	ADDRESS <u>6411 Windsor M.D. 112-7</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



11725

11724

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 31

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Balto.</i>	MARYLAND	STATE <i>Ind.</i>	COUNTY <i>Balto.</i>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>Balto 7</i>	LENGTH OF STAY (in this place) <i>5 yrs</i>	CITY (If outside corporate limits write RURAL and give nearest town) <i>Balto 7.</i>	TOWN <i>Balto 7.</i>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>3653 Campfield Rd</i>		STREET ADDRESS (If rural, give location) <i>3653 Campfield Rd</i>	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) <i>FRANK</i>	(Middle) <i>ANTHONY</i>	(Last) <i>TAMBURCO</i>	(Month) <i>Dec</i> (Day) <i>4</i> (Year) <i>1955</i>
5. SEX: <i>M.</i>	6. COLOR OR RACE: <i>W.</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>married</i>	8. DATE OF BIRTH: <i>Dec 26, 1895</i>
9. AGE last birthday: <i>59</i> yrs.		10. IF UNDER 1 YEAR: Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min.	11. IF UNDER 24 HRS. Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <i>wholesale fruit produce</i>		10b. KIND OF BUSINESS OR INDUSTRY: <i>Italy</i>	11. BIRTHPLACE (State or foreign country): <i>Italy</i>
12. CITIZEN OF WHAT COUNTRY? <i>W.S.A.</i>		13. FATHER'S NAME: <i>Jos. Tamburco</i>	
14. MOTHER'S MAIDEN NAME: <i>Rosa Bracca</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <i>no</i>	
16. SOCIAL SECURITY No.: <i>215-03-9495</i>		17. INFORMANT & ADDRESS: <i>Vincent Tamburco</i>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
Immediate cause (a)..... <i>Diabetes</i>	DUE TO	<i>6 yrs</i>
Antecedent cause(s) (b)..... <i>Diabetic tumor</i>	DUE TO	<i>15 yrs</i>
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)..... <i>cardiac decompensation</i>		<i>5 yrs</i>
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Fell down stairs steps</i>		<i>10 min</i>
19a. DATE OF OPERATION: <i>none</i>	19b. MAJOR FINDING OF OPERATION: <i>none</i>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: <i>Home</i>	21c. (City or town) (County) (State) <i>Balto Ind. Ind.</i>
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY: <i>Dec 2 55 12:30 P.M.</i>	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <i>Fell down stairs</i>
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		
SIGNATURE <i>B. D. Caples</i>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <i>12-2-55</i>
M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>		
23. BURIAL, CREMATION, REMOVAL (Specify): <i>Burial</i>	DATE THEREOF: <i>Dec. 5, 1955</i>	NAME OF CEMETERY OR CREMATORY: <i>New Cathedral</i>
LOCATION (City, town, or county) (State): <i>Baltimore, Maryland</i>	DATE REC'D BY LOCAL REG. <i>12/5/55</i>	REGISTRAR'S SIGNATURE: <i>Charles H. ...</i>
24. FUNERAL DIRECTOR: <i>Ellsworth Armacost</i>	ADDRESS: <i>4600 Liberty Heights</i>	

MARGIN RESERVED FOR BINDING

VS. A15A-5-53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

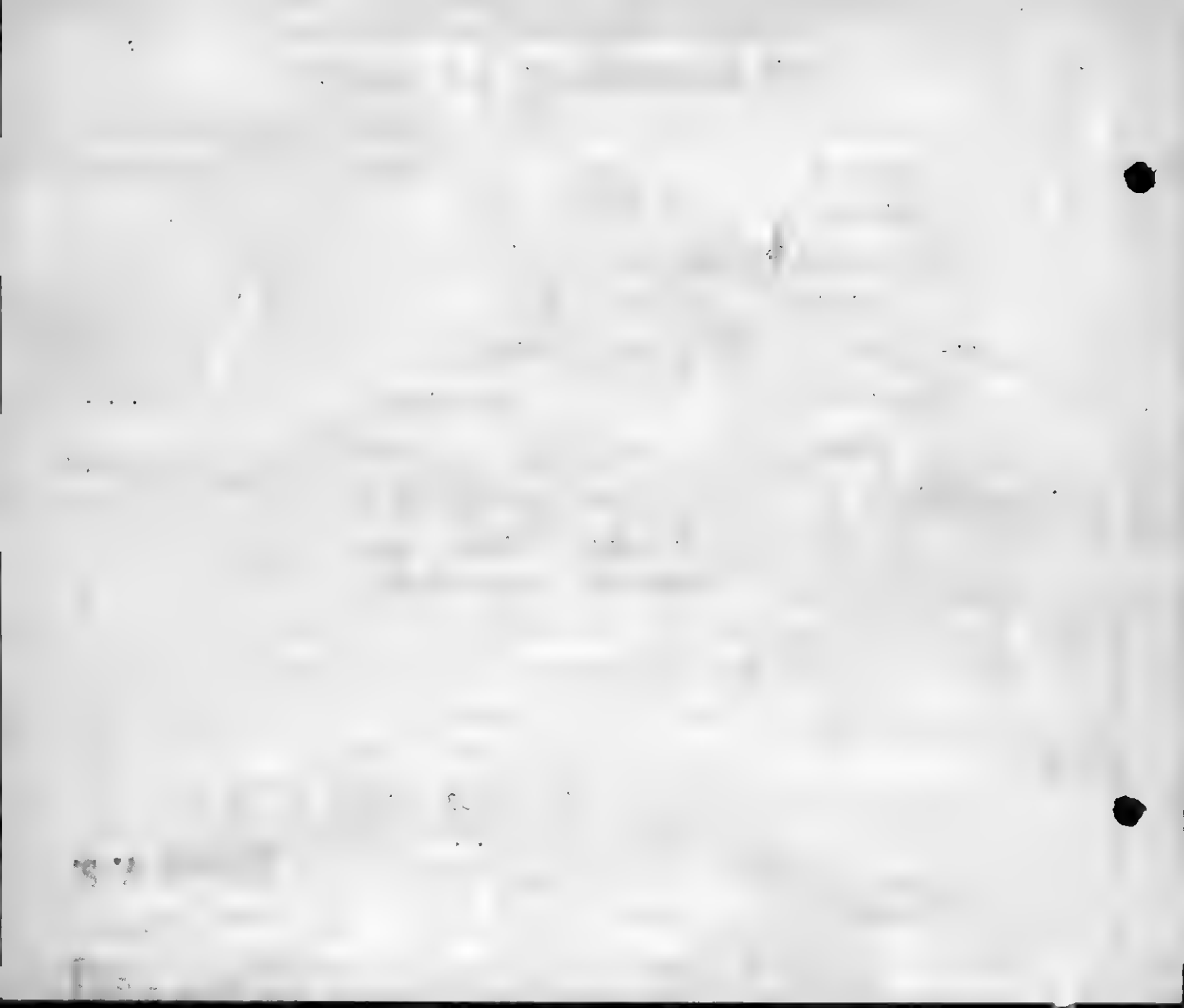
MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11726 CERTIFICATE OF DEATH

11725

Reg. Dist. No. 30

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Baltimore		MARYLAND		STATE Maryland		COUNTY Anne Arundel	
CITY (If outside corporate limits, write RURAL and give nearest town) 520 TOWN Baltimore		LENGTH OF STAY (In this place) 54 years		CITY (If outside corporate limits, write RURAL and give nearest town) O.C.K.			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 14 Spring Grove Hospital				STREET ADDRESS (If rural give location) ✓			
3. NAME OF DECEASED (Type or Print) William Richard Thompson				4. DATE OF DEATH (Month) (Day) (Year) 12 2 1955			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH 1878	9. AGE last birthday 77 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laundry work		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) Unknown		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Baltimore, 28 Spring Grove Hospital Records-			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) 450.0 Acute Cardiac Failure						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO Mental Illness							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO Generalized arteriosclerosis							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A.M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 7/1 , 19 55 , to 12/2 , 19 55 , that I last saw the deceased alive on 12/2 , 19 55 , and that death occurred at 12:45 M., from the causes and on the date stated above.							
SIGNATURE S. Vachsher		M.D. Spring Grove St. Hospital		ADDRESS (Street, city, town, state) 12/255		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Intermaled & stored		DATE THEREOF 12/2/55		NAME OF CEMETERY OR CREMATORY Univ. of Md. Med. School		LOCATION (City, town, or county) (State) Baltimore, Md.	
24. REC'D BY REGISTRAR EC 6 1955		REGISTRAR'S SIGNATURE J. E. Sherry		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	



11727

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED.	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Baltimore</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>X</u> TOWN <u>Rural Pikesville</u>	LENGTH OF STAY (in this place) <u>16 yrs.</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Pikesville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>		STREET ADDRESS (If rural give location) <u>1630 Reisterstown Rd.</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <u>Virginia</u>	(Middle) <u>M.</u>	(Last) <u>Thomson</u>	(Date) <u>Dec. 28</u> (Year) <u>1955</u>
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>Aug. 3, 1883</u>
9. AGE last birthday: <u>72</u> yrs.		10. AGE last birthday: <u>72</u> yrs.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Charles R. Stewart</u>		14. MOTHER'S MAIDEN NAME: <u>Alto Marie Sadler</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT & ADDRESS: <u>Edward A. Thomson, Pikesville, Md.</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Cirrhosis of liver</u>			<u>5 yrs.</u>
ANTECEDENT CAUSE (B) <u>Arteriosclerotic heart disease</u>			<u>10 yrs.</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>C</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY, street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>1945</u> , to <u>28 Dec., 1955</u> , that I last saw the deceased alive on <u>28 Dec.</u> , 19 <u>55</u> , and that death occurred at <u>8:30 P-M</u> , from the causes and on the date stated above.			
SIGNATURE <u>Ronnie Dahman</u>		DATE SIGNED <u>30 Dec 55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>		DATE THEREOF <u>Dec. 31, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Loudon Park Crematory</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Dec 30 1955</u>		REGISTRAR'S SIGNATURE <u>Frank H. Newell</u>	
24. FUNERAL DIRECTOR <u>Frank H. Newell</u>		ADDRESS <u>Pikesville</u>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

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11728

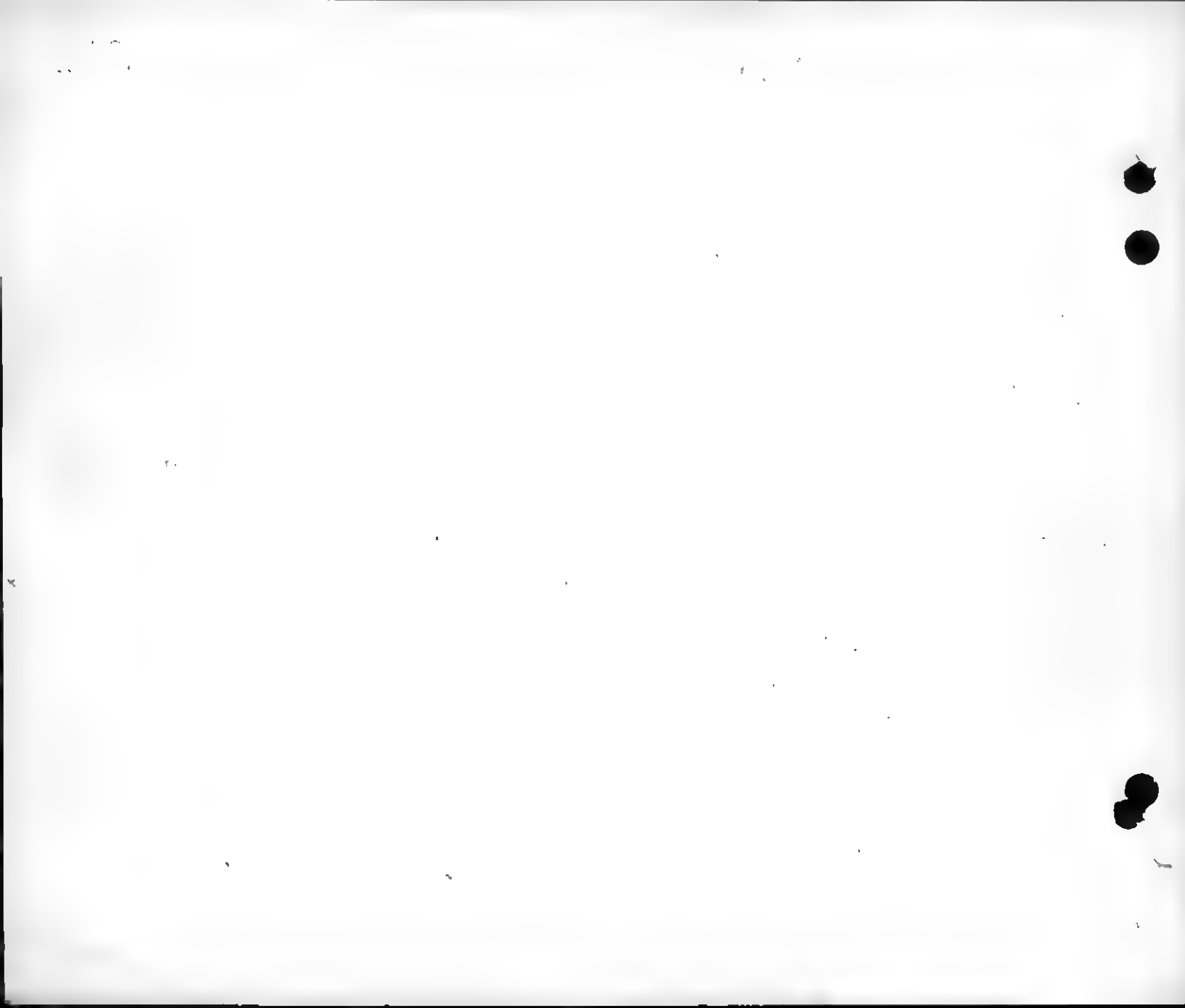
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>md</u> COUNTY <u>Baltimore</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Catonville</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Catonville</u>		(If rural, give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>625 Coleraine Road</u>				STREET ADDRESS <u>625 Coleraine Road</u>			
3. NAME OF DECEASED: (First) <u>TILLIE</u> (Middle) (Last) <u>MATILDA FOSTER-TRIPLITT</u>				4. DATE OF DEATH: <u>Dec 23</u> 19 <u>55</u>			
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH: <u>Sept 11, 1896</u>	9. AGE last birthday: <u>59</u> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Hand Wearer Unique Weaving Co</u>		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Balto Co - Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>Thomas J. Triplett</u>				14. MOTHER'S MAIDEN NAME: <u>Abbie E. Green</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.: <u>219-32-0469</u>		17. INFORMANT & ADDRESS: <u>Marie Triplett 625 Coleraine Road</u>			

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
Immediate cause (a) <u>Carcinomatosis</u>		DUE TO					
Antecedent cause(s) (b) <u>Female heart failure</u>		DUE TO					
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <u>Acute secondary anemia</u>							
II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION: <u>Dec 23, 1955</u>		19b. MAJOR FINDINGS OF OPERATION:		20. AUTOPSY?		Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) <u>SUICIDE</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>HOMICIDE</u>		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 1954</u> , to <u>Dec 23, 1955</u> , that I last saw the deceased alive on <u>Dec 23, 1955</u> , and that death occurred at <u>12:22</u> m., from the causes and on the date stated above.							
SIGNATURE <u>Thos J. Abbot</u>		(DEGREE OR TITLE) <u>Medical Doctor</u>		ADDRESS <u>4309 Liberty Heights Rd</u>		DATE SIGNED <u>12-22-55</u>	
23. BURIAL, CREMATION REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>Dec 26, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Lorraine</u>		LOCATION (City, town, or county) (State) <u>Balto Co. Md.</u>	
DATE REC'D BY LOCAL REG. <u>December 24, 1955</u>		REGISTRAR'S SIGNATURE <u>C.W.</u>		24. FUNERAL DIRECTOR <u>John F. Geufel</u>		ADDRESS <u>5311 Edmondson Ave</u>	

MARGIN RESERVED FOR BINDING



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11729

CERTIFICATE OF DEATH

Reg. Dist. No.

11728

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Md</u>	COUNTY <u>Balti</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Balti</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Balti</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Ridge Rd. Balt 7, Md</u>		STREET ADDRESS (If rural give location) <u>Ridge Rd. Balt 7, Md</u>	
3. NAME OF DECEASED: (First) <u>James</u> (Middle) <u>Michael</u> (Last) <u>Usher</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>12</u> <u>10</u> <u>1955</u>	
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>married</u>	8. DATE OF BIRTH: <u>Mar. 27, 1886</u>
9. AGE last birthday: <u>69</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Clerk</u>	11. BIRTHPLACE (State or foreign country): <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME: <u>Richard Usher</u>	
14. MOTHER'S MAIDEN NAME: <u>Mary Kenny</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>No</u>	
16. SOCIAL SECURITY NO. <u>213-03-7008</u>		17. INFORMANT & ADDRESS: <u>Viola Irene Usher - Ridge Rd.</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Aplastic Anemia</u>			<u>One Year</u>
ANTECEDENT CAUSE (S)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov.</u> , 19 <u>50</u> , to <u>Dec 10</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Dec 10</u> , 19 <u>55</u> , and that death occurred at <u>8:55 A.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>Edwin J. Purpura</u>		DATE SIGNED <u>12/10/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem</u>	
DATE THEREOF <u>12/13/1955</u>		LOCATION (City, town, or county) (State) <u>Baltimore</u>	
DATE REC'D BY LOCAL REGISTRAR		24. FUNERAL DIRECTOR <u>Ellsworth Armacost</u> ADDRESS <u>4600 Liberty Hgts. Ave.</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11730

CERTIFICATE OF DEATH

Reg. Dist. No.

11729

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>			
X <u>Fort Howard</u>		<u>3 Days</u>		<u>3x01-4</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location) <u>927 Rock Hill Avenue</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>LOUIS W. VLANGAS</u>				<u>December 7 1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>3-10-24</u>	<u>31</u> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Office Manager</u>			10B. KIND OF BUSINESS OR INDUSTRY: <u>Food Brokers</u>		11. BIRTHPLACE (State or foreign country): <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13. FATHER'S NAME: <u>William Vlangas</u>				14. MOTHER'S MAIDEN NAME: <u>Georgia Doukas</u>			
15. WAR DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service): <u>Yes</u> <u>WW II</u>		16. SOCIAL SECURITY No. <u>219 -16-8280</u>		17. INFORMANT & ADDRESS: <u>Clin.Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>LYMPHOSARCOMA INVOLVING LYMPH NODES,</u>							
ANTECEDENT CAUSE (B) <u>XRAYED LIVER AND SPLEEN</u>							<u>1 1/2 YEARS</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. (C) <u>DUE TO</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: <u>Perforating lymphosarcomatous ulcerations, ileum, with generalized peritonitis</u>							<u>RECENT</u>
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec. 4, 1955</u> , to <u>Dec. 7, 1955</u> , and that death occurred at <u>11:35 PM</u> from the causes and on the date stated above.							
SIGNATURE <u>Donald D. Mark</u>		ADDRESS <u>M. D. VAH, FORT HOWARD, MARYLAND</u>		DATE SIGNED <u>12-7-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12-10-55</u>		NAME OF CEMETERY OR CREMATORY <u>Greek Orthodox Cemetery</u>		LOCATION (City, town, or county) (State) <u>Windson Hill Road Baltimore, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>December 10 1955</u>		REGISTRAR'S SIGNATURE <u>RW</u>		24. FUNERAL DIRECTOR <u>Wm. Cook-Blight, Inc.</u>		ADDRESS <u>St. Paul & Preston Sts.</u>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10-53.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

INSTRUCTIONS

TO ATTEND:

PHYSICIAN OR HOSPITAL:

The law requires that the death certificate be executed within 24 hours after death.

1

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(141)

11730

11731

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Towson</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Towson</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>725 Hickory Lot Road</u>				STREET ADDRESS (If rural give location) <u>725 Hickory Lot Road</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Mrs. Marie J. Waldman</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>December 12 19 55</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>Oct. 13, 1895</u>	9. AGE last birthday <u>60</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME (Heinrich) <u>Henry Schilling</u>				14. MOTHER'S MAIDEN NAME <u>Mina Sporer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mr. W. Eugene Waldman, 725 Hickory Lot</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
170% IMMEDIATE CAUSE (A) <u>Metastatic carcinoma</u>						<u>1 year</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Carcinoma of left breast</u>						<u>3 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11. SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>NOV 15, 1955</u> to <u>NOV 12, 1955</u> , that I last saw the deceased alive on <u>DEC 11, 1955</u> , and that death occurred at <u>6:25</u> M. from the causes and on the date stated above.							
SIGNATURE <u>T. C. Swinski</u>				ADDRESS (Street, city, town, state) <u>17 W. Donna Ave</u>			
DATE <u>Dec 13, 1955</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Dec. 16, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
24. REC'D BY REGISTRAR <u>Dec 15, 1955</u>		REGISTRAR'S SIGNATURE <u>Mabel Gray</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Buck, 5305 Harford Road #14</u>			

The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filled with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be attached for use as a burial transit permit.

V-15C 1-55 10M

WILLIAM V. S.

1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11731

11732

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Balto.</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Balto</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
<u>X</u> TOWN		TOWN <u>114 Lyndale Ave., Balto. 6, Md.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Rosewood State Training School</u>		STREET ADDRESS (If rural give location) <u>Owings Mills, Md.</u>	
3. NAME OF DECEASED: (Type or Print) <u>Alma Marie Walsh</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>12 3 1955</u>	
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>9-28-39</u>
9. AGE last birthday <u>16</u> yrs.		10. MONTHS <u>16</u> DAYS <u>16</u> HOURS <u>16</u> MIN.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):	10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <u>Balto. Md.</u>	
13. FATHER'S NAME: <u>Charles Walsh</u>		14. MOTHER'S MAIDEN NAME: <u>Alma Seiberger</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>-</u>	17. INFORMANT & ADDRESS: <u>Rosewood St. Tr. School</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Interstitial Pneumonia of right lung</u>			<u>3 days</u>
ANTECEDENT CAUSE (B) <u>General weakness due to spastic quadriplegia</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>→</u>			
19A. DATE OF OPERATION: <u>12/2/55</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>3:29</u> , 19 <u>55</u> , to <u>12/2</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12/2</u> , 19 <u>55</u> , and that death occurred at <u>12:45 AM</u> , from the causes and on the date stated above.			
SIGNATURE <u>David J. Vail</u>		ADDRESS <u>BALTIMORE 6, MD.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>12-5-55</u>		REGISTRAR'S SIGNATURE <u>Philip E. Cyach</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>12-6-1955</u>	
NAME OF CEMETERY OR CREMATORY <u>HOLY REDEEMER</u>		LOCATION (City, town, or county) (State) <u>BALTIMORE 6, MD.</u>	
24. FUNERAL DIRECTOR <u>PHILIP E. CYACH</u>		ADDRESS <u>2716 MONUMENT ST.</u>	



11554

CERTIFICATE OF DEATH

Reg. Dist. No.

42

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Balto</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>51 TOWN arbutus</u>		LENGTH OF STAY (in this place) <u>1 month</u>		CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Baltimore</u>		31114	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1285 Poplar Ave - Balto, 27th</u>				STREET ADDRESS (If rural give location) <u>736 E. Preston St.</u>			
3. NAME OF DECEASED: (Type or Print)		(First) <u>Minnie</u>		(Middle) <u>Margaret</u>		(Last) <u>WARD</u>	
4. DATE OF DEATH:		(Month) <u>Dec</u>		(Day) <u>4</u>		(Year) <u>1951</u>	
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>		8. DATE OF BIRTH: <u>Jan 23, 1877</u>	
9. AGE last birthday: <u>78</u> yrs.		IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____		IF UNDER 24 HRS. _____			
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: <u>nurse</u>				10b. KIND OF BUSINESS OR INDUSTRY: <u>Medicine</u>		11. BIRTHPLACE (State or foreign country): <u>North Carolina</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME: <u>Samuel J. Ward</u>				14. MOTHER'S MAIDEN NAME: <u>Mary Francis Mason</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY No.: <u>unknown</u>		17. INFORMANT & ADDRESS: <u>Mrs. Baumer 1335 Poplar Ave Balto 27th</u>	

18. MEDICAL CERTIFICATION		Interval Between Onset And Death <u>1 week</u> <u>15 years</u>
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
(a) Immediate cause <u>Heart failure</u>		
(b) Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. <u>Arteriosclerosis Heart disease</u>		
(c) DUE TO		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>None</u>		
19a. DATE OF OPERATION: _____		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
19b. MAJOR FINDINGS OF OPERATION _____		

21. ACCIDENT (Specify) _____		PLACE (Home, farm, factory, street, office bldg., etc.) _____		(CITY OR TOWN) _____		(COUNTY) _____		(STATE) _____	
HOMICIDE _____		INJURY _____		HOW DID INJURY OCCUR? _____					
TIME (Month) (Day) (Year) (Hour) (Minute) _____		INJURY OCCURRED _____							
OF INJURY _____		While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							

22. I hereby certify that I attended the deceased from June 1951, to 3 Dec 1951, that I last saw the deceased alive on 3 Dec 1951, and that death occurred at 8:15 AM, from the causes and on the date stated above.

SIGNATURE William Goodman (Degree or title) MD ADDRESS 1334 Lupton Ave Balto DATE SIGNED 4 Dec 55

23. MANNER OF REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>Dec 5 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Durham</u>	LOCATION (City, town, or county) <u>Balto</u>	(State) <u>MD</u>
DATE REC'D BY LOCAL REGISTRAR <u>Dec 8 - 55</u>	REGISTRAR'S SIGNATURE <u>A.W. Helmer</u>	24. FUNERAL DIRECTOR <u>Leo E. Cook</u>		ADDRESS <u>1200 N. Patterson Park</u>

MARGIN RESERVED FOR INDEXING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

11733

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 44

11733

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Bethesdens Point</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Edgemere</u> TOWN <u>(19)</u>	
HOSPITAL OR INSTITUTION OR <u>Bethlehem Steel Dispensary</u> STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>3201 Riverdrive Road</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Russell</u>	(Middle) <u>DAVIS</u>	(Last) <u>Watson</u>
4. DATE OF DEATH	(Month) <u>12</u>	(Day) <u>15</u>	(Year) <u>1955</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <u>MARRIED</u> WIDOWED <u>MARRIED</u> (Specify)	8. DATE OF BIRTH <u>FEB 1, 1890</u>
9. AGE last birthday <u>65</u> yrs.		10. If under 1 year Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>STEEL MFR.</u>	
11. BIRTHPLACE (State or foreign country) <u>PENNA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOSEPH WATSON</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN -</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>213-07-1670</u>	
17. INFORMANT AND ADDRESS <u>FLORENCE L. WATSON -</u>		<u>same</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Coronary Occlusion

Antecedent cause(s)

Diseases or conditions, if any,
giving rise to the above cause
stating the underlying cause last

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not
related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒21. EXTERNAL CAUSE WAS
PRIMARY ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH.PLACE (Home, farm, factory, street,
OR office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)
OF INJURY m.INJURY OCCURRED
While at work ☐ Not while
at work ☐

HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION
REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

DEC 22 1955

Lawson L. FarleyWalter Alberts1715/55

MARGIN RESERVE FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

DEC 22 195

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11734

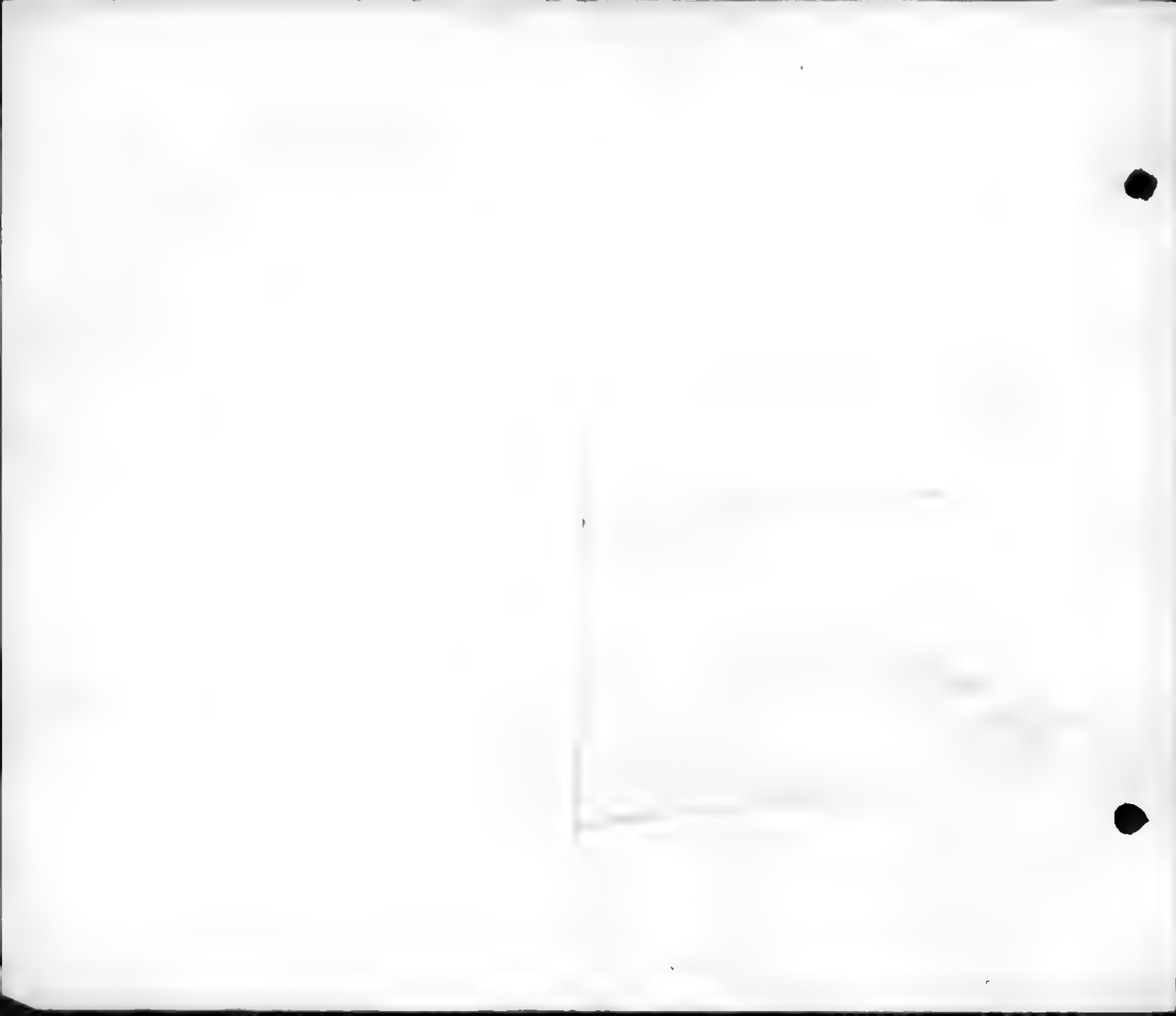
CERTIFICATE OF DEATH

11734

Reg. Dist. No. 30...

Item 12, F12-MG190 12-27-55 et

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Md</u>	COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Baltonsville</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Baltimore</u>	3Y.
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>House in Pines</u>		STREET ADDRESS (If rural give location) <u>309 Cathedral St.</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>MORRIS WEINSTEIN</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>12-19-1955</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE. MARRIED. WIDOWED. DIVORCED. (Specify) <u>Married</u>	8. DATE OF BIRTH:
9. AGE last birthday <u>76</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>grocer</u>		10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <u>Russia</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME: <u>Morris</u>	
14. MOTHER'S MAIDEN NAME: <u>not known</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>William Weinstein - same</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Acute Pulmonary Congestion</u>			<u>3da.</u>
ANTECEDENT CAUSE (B) <u>Myocardial Infarction</u>			<u>2wks.</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Ch. Hypertensive C. v. B. Disease</u>			<u>5yr.?</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, street, office bldg., etc.)	21C. WHERE DID (City or town) INJURY OCCUR?	(County) (State)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>2-26, 1955</u> , to <u>12-19, 1955</u> , that I last saw the deceased alive on <u>12-18, 1955</u> , and that death occurred at <u>6 A</u> M, from the causes and on the date stated above.			
SIGNATURE <u>William K. Gallagher</u>		DATE SIGNED <u>M. D. 6209 Frederick Rd. Balt. 28. 12/19/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>12-20-55</u>	NAME OF CEMETERY OR CREMATORY <u>United Hebrew</u>	LOCATION (City, town, or county) (State) <u>Balto Md</u>
DATE REC'D BY LOCAL REGISTRAR <u>12-20-55</u>	REGISTRAR'S SIGNATURE <u>Jack Lewis</u>	24. FUNERAL DIRECTOR <u>2100 Eutan Rd</u>	



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 16, 22 Film 190 12-21-55 e

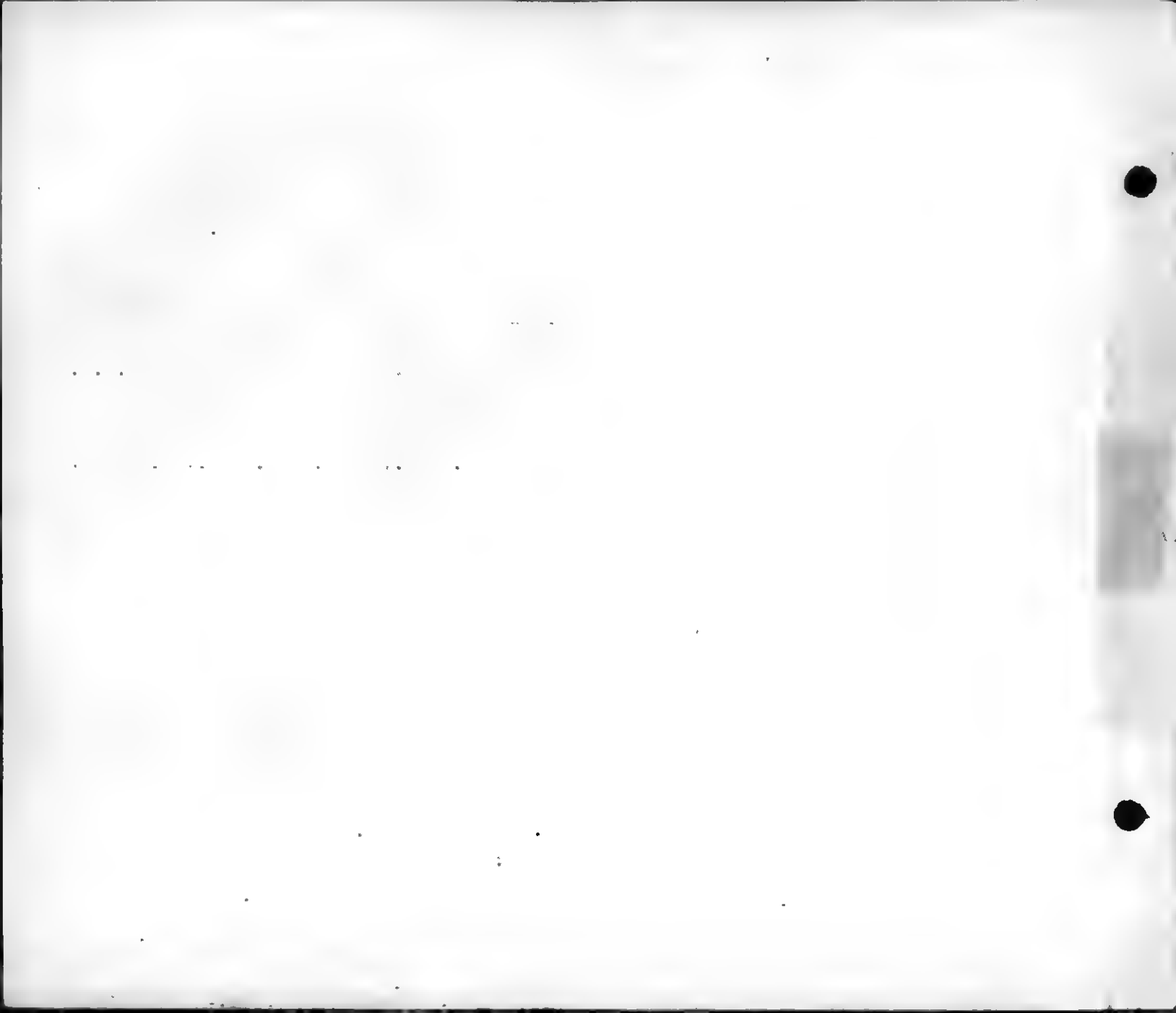
11735

CERTIFICATE OF DEATH

Reg. Dist. No. 44

11735

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR			
X TOWN <u>Fort Howard</u>		<u>48 Days</u>		TOWN <u>Baltimore</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>50 Veterans Administration Hospital</u>				<u>2303 Edmondson Ave.</u>			
3. NAME OF DECEASED:				4. DATE (Month) (Day) (Year) OF DEATH:			
(First) <u>WILLIAM</u>		(Middle) <u>(NMI)</u>		(Last) <u>WELLS</u>		December 17 1955	
(Type or Print)							
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>Colored</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>6-21-95</u>	
						9 AGE last birthday <u>60 yrs.</u>	
						IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Longshoreman</u>				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Hobson, Virginia</u>	
13. FATHER'S NAME: <u>Orano Wells</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
14. MOTHER'S MAIDEN NAME: <u>Nettie Hall</u>				17. INFORMANT & ADDRESS: <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>WW 1</u>				16. SOCIAL SECURITY NO. <u>217-03-2925</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (A) <u>BRONCHOGENIC CARCINOMA WITH METASTASES</u>				1 YEAR			
ANTECEDENT CAUSE (B) <u>ARTHROITIS HYPEPTROPHI</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>11/21/55</u>		19B. MAJOR FINDINGS OF OPERATION: <u>METASTATIC CARCINOMA IN RIB AND STRIATED MUSCLE</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: <u>VA</u> M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Oct. 10, 1955, to Dec. 17, 1955, that I last saw the deceased alive on <u>19 Dec 1955</u> and that death occurred at <u>2:00 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>DAVID H. VATTEN</u>		M. D. <u>FORT HOWARD, MD.</u>		DATE SIGNED <u>12-18-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12-21-55</u>		NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>12-21-55</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>Charles G. Cooper Funeral Home</u>		ADDRESS <u>1111 N. Carrollton Ave., Baltimore, Md.</u>	



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

11736
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11736
Reg. Dist.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Ind</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Catonsville</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) <u>Catonsville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>120 Federal Rd</u>				STREET ADDRESS (If rural, give location) <u>120 Federal Rd</u>			
3. NAME OF DECEASED: (Type or Print) <u>Mary H Whitten</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Dec 18 1953</u>			
5. SEX: <u>7</u>	6. COLOR OR RACE: <u>w</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>July 11 1873</u>	9. AGE last birthday: <u>82</u> yrs.		IF UNDER 1 YEAR (Months) (Days) IF UNDER 24 HRS. (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of work life even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Co. Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Howard</u>				14. MOTHER'S MAIDEN NAME: <u>don't know</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY No.: <u>no</u>		17. INFORMANT & ADDRESS: <u>Jiles R. Knorr, 1510 Eastfield Rd</u>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: <u>429.1</u> Immediate cause (a)..... DUE TO..... Antecedent cause(s) (b)..... Diseases or conditions, if any, giving rise to the above cause DUE TO..... stating underlying cause last (c).....							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION: <u>8</u>		19b. MAJOR FINDING OF OPERATION:					20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.							
SIGNATURE <u>Dr. McKieffer</u>		1010 Leiden		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>Dec 19 1953</u>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>12/21/53</u>		NAME OF CEMETERY OR CREMATORY <u>First United Evangelical Church Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
DATE REC'D BY LOCAL REG. <u>12-20-53</u>		REGISTRAR'S SIGNATURE <u>H. W. L. L. L.</u>		24. FUNERAL DIRECTOR <u>H. M. Book, Inc., 1217 E. Paul St.</u>			



1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12576

11737

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u> MARYLAND				STATE <u>Md.</u> COUNTY <u>Baltimore</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Fullerton</u> <u>Twks</u>				CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cockeysville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Silver Spring Rd</u>				STREET ADDRESS (If rural give location) <u>York Rd</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Ida</u> (Middle) <u>Nora</u> (Last) <u>Wilhelm</u>				(Month) <u>Dec.</u> (Day) <u>3</u> (Year) <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Widowed</u>	<u>7 February, 1974</u>	<u>81</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>				<u>Beckleysville Md.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>John Hampshire</u>				<u>Sophie Eberg</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>no</u> (If Yes, give war or dates of service)		<u>none</u>		<u>Rose Edith Miller</u> <u>Daughter</u> <u>Fullerton, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Arterio sclerotic Cardio vascular disease</u>						<u>3 yrs</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED W <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July</u> , 19 <u>53</u> , to <u>Dec</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Nov</u> , 19 <u>53</u> , and that death occurred at <u>2 P</u> .M., from the causes and on the date stated above.							
SIGNATURE <u>Walter J. Kees</u>				ADDRESS (Street, city, town, state) <u>Cockeysville Md</u>		DATE SIGNED <u>3 Dec. 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>12-6-55</u>		<u>Foreston Baptist</u>		<u>24ppaca. Baltol. Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>12-5-55</u>		<u>Walter J. Kees</u>		<u>Joseph Brown</u>		<u>Sparks, Md.</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OF HOSPITAL: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 AISC 1-55 10M



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11737

11738 CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Catonsville</u> LENGTH OF STAY (In this place) <u>6y. 4mo 23d.</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u> <u>3rd</u> STREET ADDRESS (If rural give location) <u>2815 Kennedy Ave</u> ✓			
3. NAME OF DECEASED (Type or Print) (First) <u>Ida</u> (Middle) <u>G.</u> (Last) <u>Wilkinson</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>12/5/1955</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widow</u>	8. DATE OF BIRTH <u>10/8/1866</u>	9. AGE last birthday <u>89</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Ernest Luthardt</u>				14. MOTHER'S MAIDEN NAME <u>Marie; last name unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>unk.</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>unk.</u>		17. INFORMANT & ADDRESS <u>This Hospital's Records</u>			
18. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
I. IMMEDIATE CAUSE (A) <u>Heart Failure</u>						<u>1 day</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
DUE TO (B) <u>Arteriosclerotic cardiovascular disease</u>						<u>years</u>	
DUE TO (C) <u>Generalized arteriosclerosis</u>						<u>years</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>C</u>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>7/1/1953</u> , to <u>12/5/1955</u> , that I last saw the deceased alive on <u>12/5/1955</u> , and that death occurred at <u>11:10p.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Bruno Radauskas</u> M.D.				ADDRESS (Street, city, town, state) <u>Spring Grove St. Hosp.</u>		DATE SIGNED <u>12/5/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2/9/55</u>		NAME OF CEMETERY OR CREMATORY <u>Mount Pleasant</u>		LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
24. REC'D BY REGISTRAR DATE <u>DEC 8</u>		REGISTRAR'S SIGNATURE <u>V. E. Harris</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>L. G. Ruckelshaus</u>		ADDRESS <u>5305 Harper Rd.</u>	



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

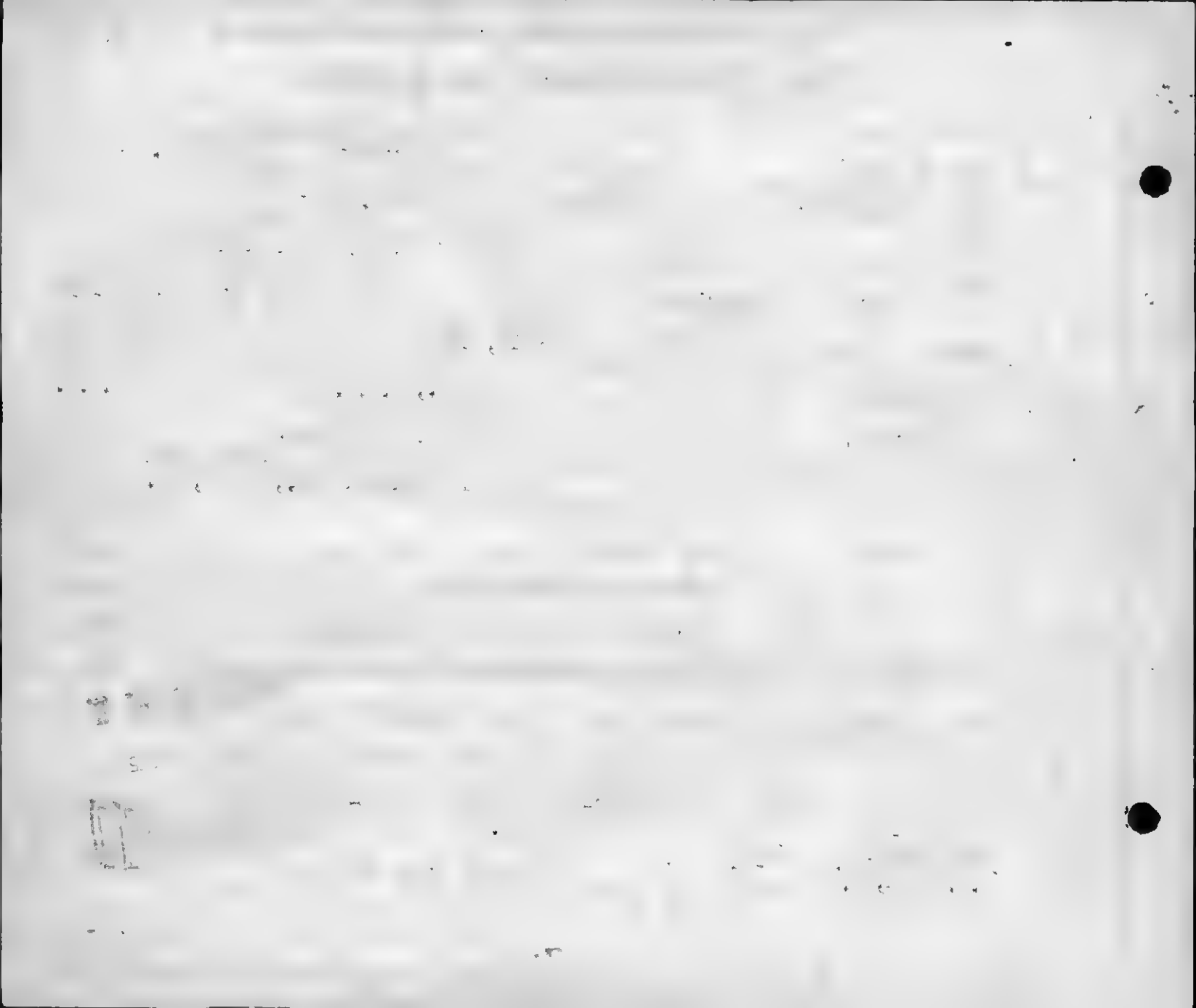
11739

11739

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Baltimore		MARYLAND		STATE Maryland		COUNTY Balto. City	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Catonsville		1 1/2 months		TOWN Balto. City (2a)		53	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Spring Grove State Hosp.				STREET ADDRESS (If rural give location) 7142 Martell Avenue			
3. NAME OF DECEASED (Type or Print) Mary Katherine Wilson				4. DATE OF DEATH (Month) Dec (Day) 4 (Year) 1955			
5. SEX Female		6. COLOR OR RACE White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow		8. DATE OF BIRTH June 10, 1885	
				9. AGE last birthday 70 yrs.		IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Penna., U.S.A.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME James Wilson FREDERICKSON.				14. MOTHER'S MAIDEN NAME (?) Monahan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS George Wilson 7142 Martell Ave., Balto, Md.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
539.1 IMMEDIATE CAUSE (A) Bronchopneumonia						5 days	
ANTECEDENT CAUSE(S) DUE TO (B) Inanition and dehydration						1 month	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Achalia (cardiospasm) of esophagus						??	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Rt cystic hydronephrosis due to old operative scar						??	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 10-12 , 19 55 , to 12-4 , 19 55 , that I last saw the deceased alive on 12-4 , 19 55 , and that death occurred at 9:00 AM , from the causes and on the date stated above.							
Sig. of Doctor J. B. Cowen, M.D.						DATE SIGNED 12-4-55	
M.D. Spring Grove Hospital							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF 12-6-55		NAME OF CEMETERY OR CREMATORY SACRED HEART CEM.		LOCATION (City, town, or county) (State) 7401 GERMAN HILL RD. BALTO. CO., MD.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE Charles L. Feiler 9015 CONKLING ST. BALTO., MD.			



11740

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Balto</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Balto</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Lutherville</u>		<u>2 yrs</u>		TOWN <u>Lutherville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>GEORGE</u> (Middle) <u>H</u> (Last) <u>WISNER</u>				(Month) <u>Dec</u> (Day) <u>14</u> (Year) <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>M</u>	<u>W</u>	<u>Married</u>	<u>Oct 11-1916</u>	<u>39</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Harmer</u>			<u>Harmer</u>	<u>Maryland</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Wm H Wisner</u>				<u>Elizabeth A Hedrick</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>214-14-6469</u>		<u>Mrs Geo H Wisner, Lutherville Md</u>			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Cancer of Colon</u>						<u>24 Mos.</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<u>1955 11</u>		<u>Cancer</u>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12-9</u> , 19 <u>55</u> , to <u>12-14</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12-14</u> , 19 <u>55</u> , and that death occurred at <u>8:33 PM</u> , from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>Bennett A. Storer M.D.</u>				<u>Lutherville, Md</u>		<u>12/14/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Dec 17/55</u>		<u>Forest Baptist chch</u>		<u>Balto Co Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>12-16-55</u>		<u>Mary B. Eline</u>		<u>Edw. J. Tapscott</u>		<u>Hampden Md</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1996

11741

CERTIFICATE OF DEATH

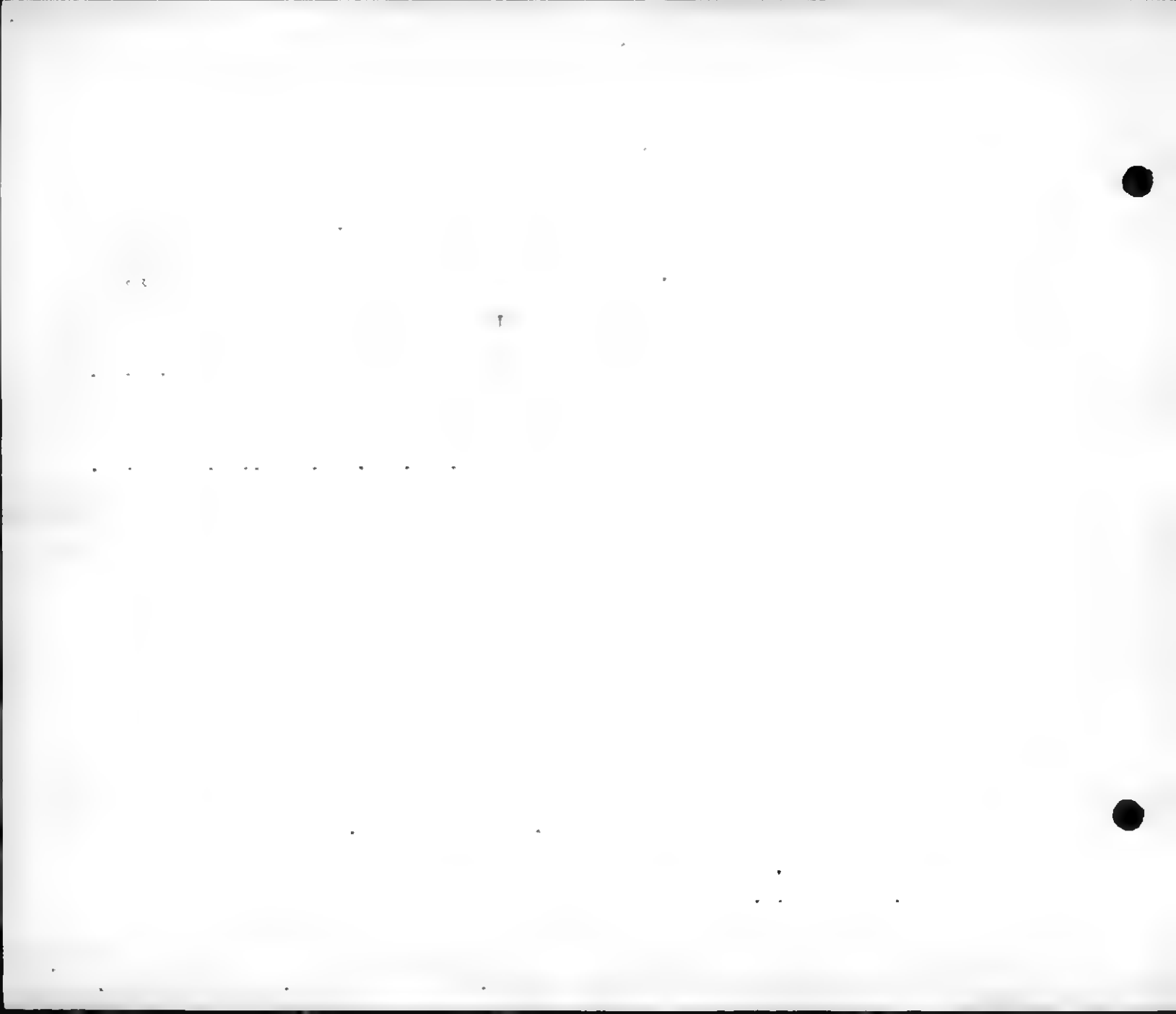
Reg. Dist. No. 4 f

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY	Baltimore	STATE	Maryland
CITY (If outside corporate limits, write RURAL or and give nearest town)	Fort Howard	COUNTY	
TOWN		CITY (If outside corporate limits, write RURAL and give nearest town)	Baltimore
HOSPITAL OR INSTITUTION OR STREET ADDRESS	Veterans Administration Hospital	STREET ADDRESS (If rural give location)	410 N. Madeira Street
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year) OF DEATH:	
WILLIAM J. WITTIG		December 1, 1955	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:
Male	White	Married	11/30/14
9. AGE last birthday:		10. BIRTHPLACE (State or foreign country):	
41 yrs.		Baltimore, Maryland	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		12. CITIZEN OF WHAT COUNTRY?	
Laborer		U. S. A.	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
George Wittig		Lillie Mae Gross	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
Yes		Unknown	
17. INFORMANT & ADDRESS:		18. MEDICAL CERTIFICATION	
Clin. Rec. Vet. Adm. Hosp., Ft. Howard, Md.		I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	
IMMEDIATE CAUSE		(A) UREMIA	
ANTECEDENT CAUSE (S)		DUE TO CHRONIC GLOMERULONEPHRITIS	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(B)	
		DUE TO	
		(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		INTERVAL BETWEEN ONSET AND DEATH	
		UNKNOWN	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that VA attended the deceased from Nov. 30, 1955 to Dec. 1, 1955, that he was the deceased and that death occurred at 11:35 PM, from the causes and on the date stated above.			
SIGNATURE		ADDRESS	
JAMES J. NOLAN, M.D.		M. D. VAH, FORT HOWARD, MARYLAND	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	
Burial		DEC 6, 1955	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Oak Lawn Cemetery		Baltimore, Maryland	
DATE REC'D BY LOCAL REGISTRAR		24. FUNERAL DIRECTOR	
12/5/55		Wm. Cook-Blight, Inc.	
REGISTRAR'S SIGNATURE		ADDRESS	
		6009 Harford Rd., Balto.	

MARGIN RESERVED FOR BINDING

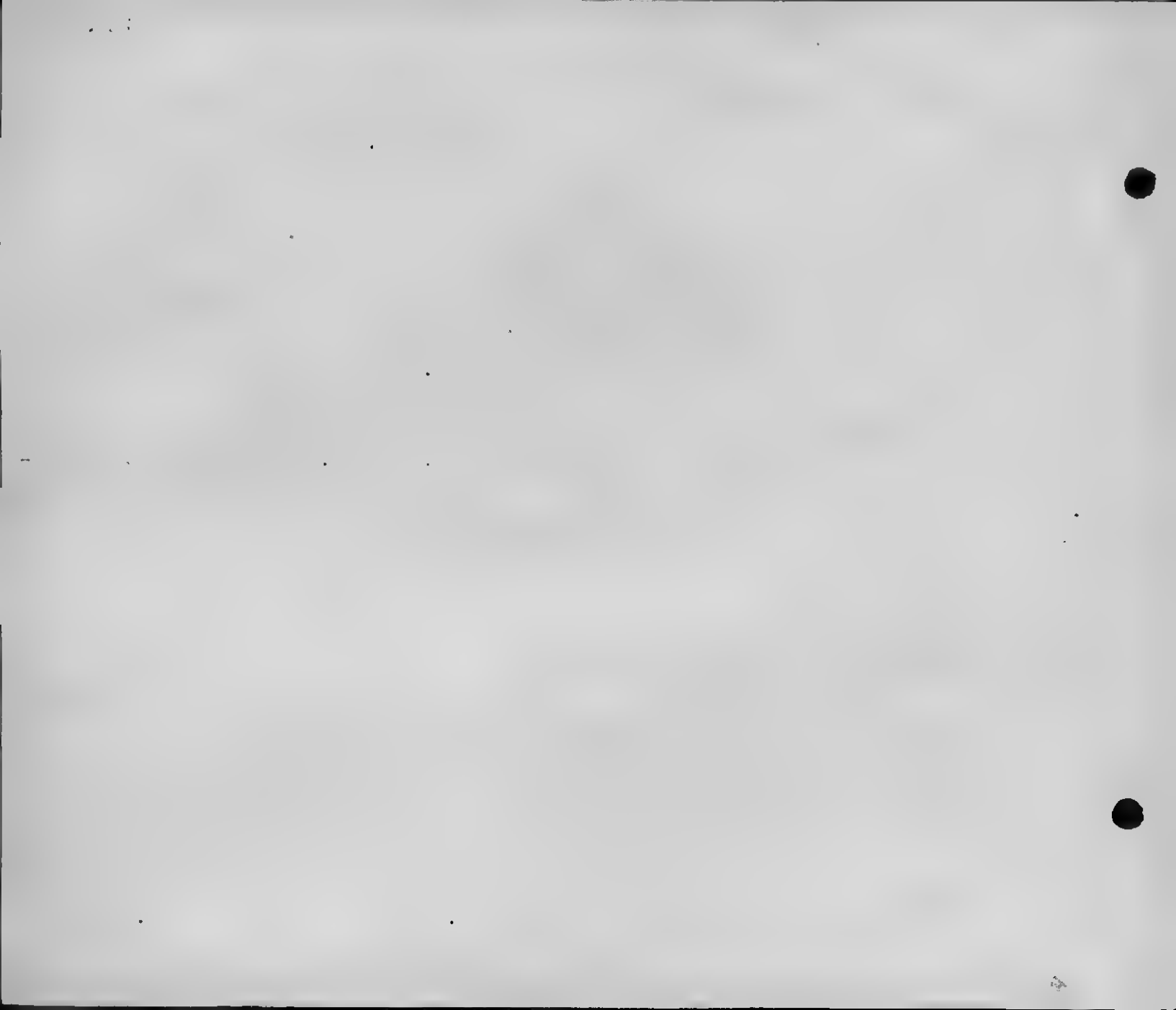
VS. A15 - 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

11742				11742			
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18							
MEDICAL EXAMINER'S CERTIFICATE OF DEATH							
1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY		BALTIMORE		STATE		Md.	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		Lutherville		COUNTY		1	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		Falls Rd.		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN		Lutherville	
3. NAME OF DECEASED:		(First) NANCY		(Middle) KATHLEEN		(Last) WOOD	
4. DATE OF DEATH		12-9		5. AGE last birthday:		19 55	
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:	
female		white		single		Sept. 16, 1955	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
---		---		Md.		---	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
Allen Hunt Wood				Nancy Carnes			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)				16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:	
1-						ville Mr. Allen H. Wood - Falls Rd., Lutherville	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
500X Immediate cause (a) ACUTE LARYNGO TRACHEO BRONCHITIS DUE TO							
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
2							
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County)		(State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE				DATE SIGNED			
R. F. Fisher				12-10-55			
23. BURIAL, CREMATION, REMOVAL (Specify):				24. FUNERAL DIRECTOR			
Burial				Pikesville, Md.			
DATE REC'D BY LOCAL REG.				ADDRESS			
12/12/55				17th			



11743

CERTIFICATE OF DEATH

Reg. Dist. No. 45

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Balto.</u>		MARYLAND		STATE <u>md.</u>		COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Essex</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Essex</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>60 Riverside Rd.</u>				STREET ADDRESS (If rural, give location) <u>60 Riverside Rd.</u>			
3. NAME OF DECEASED: (First) <u>Elischa</u> (Middle) <u>E.</u> (Last) <u>Yancey</u>				4. DATE OF DEATH: (Month) <u>12</u> (Day) <u>7</u> (Year) <u>1955</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>W</u>		8. DATE OF BIRTH: <u>May. 30 - 1980</u>	
9. AGE last birthday: <u>75</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Blacksmith</u>		11. BIRTHPLACE (State or foreign country): <u>Va.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>Unknown</u>				14. MOTHER'S MAIDEN NAME: <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>Wm Yancey, Essex, Md.</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
151X Immediate cause (a) <u>CIT Coronary</u> DUE TO						<u>an hr.</u>	
Antecedent cause(s) (b) <u>Arteriosclerosis</u> DUE TO						<u>2 yrs.</u>	
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <u>Arteriosclerosis</u>							
II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. <u>Diastolic asis</u>							
19a. DATE OF OPERATION: <u>✓</u>				19b. MAJOR FINDINGS OF OPERATION:			
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>							
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan.</u> , 19 <u>51</u> , to <u>12/7</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>12/7</u> , 19 <u>55</u> , and that death occurred at <u>7 P.</u> m., from the causes and on the date stated above.							
SIGNATURE <u>J. H. Bell</u>				(DEGREE OR TITLE) <u>md</u>		ADDRESS <u>Essex, Md.</u>	
23. BURIAL, CREMATION REMOVAL (Specify): <u>Buried</u>		DATE THEREOF <u>12/10/55</u>		NAME OF CEMETERY OR CREMATORY <u>Thomas</u>		LOCATION (City, town, or county) (State) <u>Smith Co. Va. Md.</u>	
DATE REC'D BY LOCAL REG. <u>12/19/55</u>		REGISTRAR'S SIGNATURE <u>Edith Hurley</u>		24. FUNERAL DIRECTOR <u>John J. Connelly</u>		ADDRESS <u>Essex, Md.</u>	

MARGIN RESERVED FOR BINDING

BUREAU V. S.

DEC 14 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11744

11744 CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTIMORE</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>BALTIMORE</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>KEISTERSTOWN</u>		<u>34 YRS.</u>		TOWN <u>KEISTERSTOWN</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>CHURCH ROAD</u>				STREET ADDRESS (If rural give location) <u>CHURCH ROAD</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>EMMA</u> (Middle) <u>—</u> (Last) <u>YINGLING</u>				(Month) (Day) (Year) <u>DECEMBER 16 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>FEMALE</u>	<u>WHITE</u>	<u>MARRIED</u>	<u>MAY 20, 1874</u>	<u>81</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>LOUIS BACHMAN</u>				14. MOTHER'S MAIDEN NAME <u>ELISE KERN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>HUSBAND - SAME ADDRESS</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
422.1 IMMEDIATE CAUSE (A) <u>PULMONARY EDEMA</u>				<u>10 HRS.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>ARTERIOCLEROTIC C.V. DISEASE</u>				<u>10 YRS.</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH							
19a. DATE OF OPERATION <u>—</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>APRIL 19, 1948</u> , to <u>DECEMBER 16, 1955</u> , that I last saw the deceased alive on <u>DEC. 16, 1955</u> , and that death occurred at <u>12:15 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Martin E. Strubel</u>				ADDRESS (Street, city, town, state) <u>KEISTERSTOWN, MD.</u>		DATE SIGNED <u>12/16/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Dec 19 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
24. REC'D BY REGISTRAR <u>12-18-55</u>		REGISTRAR'S SIGNATURE <u>Mary B. Zline</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Berryman</u>		ADDRESS <u>Reisterstown Md</u>	

CERTIFICATE OF DEATH

DATE OF DEATH

<p>1. Name of Deceased</p>		<p>2. Sex</p>		<p>3. Age</p>	
<p>4. Date of Birth</p>		<p>5. Place of Birth</p>		<p>6. Usual Residence</p>	
<p>7. Cause of Death</p>		<p>8. Manner of Death</p>		<p>9. Date of Death</p>	
<p>10. Signature of Physician</p>		<p>11. Signature of Registrar</p>		<p>12. Date of Registration</p>	

BUREAU V. S.

DEC 22 1955

RECEIVED

NOTICE: This certificate is to be filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland. It is to be retained for a period of ten years. It is to be made available to the public upon request. It is to be destroyed after ten years.

11745

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u> MARYLAND		STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Fort Howard</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u> 3Vo1-4	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>50 Veterans Administration Hospital</u>		STREET ADDRESS (If rural give location) <u>1843 Presstman Street</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>RICHARD S. T. YOUNG</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>December 9 1955</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>9-23-78</u>
9. AGE last birthday: <u>77</u> yrs.		10. BIRTHPLACE (State or foreign country): <u>Baltimore, Maryland</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Porter</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME: <u>Notley L. Young</u>		14. MOTHER'S MAIDEN NAME: <u>Elizabeth Neal</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes</u> <u>OW</u>		16. SOCIAL SECURITY NO. <u>212-05-5420</u>	
17. INFORMANT & ADDRESS: <u>CLIN.REC., VET.ADM.HOSP., FT. HOWAR D, MD</u>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>151X CARCINOMA OF STOMACH WITH METASTASES TO LIVER</u>		9 MONTHS	
ANTECEDENT CAUSE (B) <u>DUE TO</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>12/7/55</u>		19B. MAJOR FINDINGS OF OPERATION: <u>Exploratory Laparotomy</u>	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Nov. 17, 1955</u> , to <u>Dec. 9, 1955</u> , that death occurred <u>death occurred</u> <u>12/9/55</u> and that death occurred at <u>5:15 A.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Donald D. Mark</u>		ADDRESS <u>M. D. VAH FT. HOWARD MD</u>	
DATE SIGNED <u>12/9/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12/12/1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Dec 10. 1955</u>		REGISTRAR'S SIGNATURE <u>R.W.</u>	
24. FUNERAL DIRECTOR <u>Katie R. Williams</u>		ADDRESS <u>322 N. Schroeder St. Balto. Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

